

AMENDED IN ASSEMBLY APRIL 20, 2009

CALIFORNIA LEGISLATURE—2009—10 REGULAR SESSION

ASSEMBLY BILL

No. 1543

Introduced by Committee on Health (Jones (Chair), Fletcher (Vice Chair), Adams, Ammiano, Block, Carter, Conway, De La Torre, Emmerson, Hall, Hayashi, Hernandez, Bonnie Lowenthal, Nava, V. Manuel Perez, Salas, and Audra Strickland)

March 4, 2009

An act to amend Sections 1358.4, 1358.6, 1358.8, 1358.9, 1358.11, 1358.13, 1358.17, 1358.18, and 1358.20 of, and to add Sections 1350.1, 1358.81, 1358.91, and 1358.24 to, the Health and Safety Code, and to amend Sections 785, 10192.4, 10192.6, 10192.8, 10192.9, 10192.11, 10192.12, 10192.13, 10192.17, 10192.18, 10192.20 of, and to add Sections 10192.81, 10192.91, and 10192.24 to, the Insurance Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1543, as amended, Committee on Health. Medicare supplement ~~coverage~~. *coverage: Medicare advantage.*

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires plans and insurers that issue Medicare supplement contracts or policies, as defined, to comply with specified requirements.

The federal Medicare Improvements for Patients and Providers Act of 2008 requires states to adopt, by September 24, 2009, certain

modernization changes to Medicare supplement policies made in a specified model law developed by the National Association of Insurance Commissioners.

In addition, the federal Genetic Information Nondiscrimination Act of 2008, prohibits an issuer of a Medicare supplemental policy from denying or conditioning the issuance or effectiveness of the policy, and from discriminating in the pricing of the policy, on the basis of genetic information, as specified. The act further prohibits an issuer of a Medicare supplemental policy from, among other things, requesting or requiring an individual or a family member of that individual to undergo a genetic test, as specified. The act requires states to make changes needed to conform to these requirements by July 1, 2009.

~~With respect to health insurers that issue Medicare supplement policies, this~~

This bill would make those conforming changes and would adopt the modernization changes made in the model law developed by the National Association of Insurance Commissioners. The bill would declare the intent of the Legislature to make the same changes to the Knox-Keene Act.

~~Existing law authorizes a Medicare supplement policy to limit coverage exclusively to a single disease or affliction.~~

~~This bill would instead require a Medicare supplement policy to cover the applicable coinsurance and deductible for any illness or disease covered by Medicare, plus expenses for any illness or disease covered by the individual's applicable Medicare supplement plan.~~

Existing law provides that a person is eligible for the guaranteed issue of a Medicare supplement plan if the person is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits.

This

With respect to health insurers that issue Medicare supplement policies, this bill would instead provide that a person is eligible for the guaranteed issue of a Medicare supplement plan if the person is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates or ceases to provide some, all, or substantially all of those supplemental health benefits, or also require that the employer no longer provides provide the individual with insurance that covers all of the payment for the Part B 20% coinsurance.

Existing law prohibits an issuer from requiring or requesting health information from an applicant who is guaranteed Medicare supplement coverage and from requiring or requesting that applicant to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996.

This

With respect to health insurers that issue Medicare supplement policies, this bill would instead prohibit an issuer from using the applicant's health information for the purpose of determining eligibility for coverage.

Existing law provides for the federal Medicare Program, which provides health care benefits, including prescription drug benefits, to persons 65 years of age and older and other specified persons. Existing law establishes the Medicare Advantage program, which allows beneficiaries of the Medicare Program to enroll in private health plans to receive Medicare-covered benefits.

This bill would require a health care service plan that arranges to provide health care services in this state pursuant to the Medicare Advantage program to be licensed under the Knox-Keene Act and to comply with all requirements under that act except to the extent preempted by federal law. The bill would require that any other arrangement for health care services comply with the act to the extent applicable.

Because a willful violation of the bill's requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The bill would make other conforming-~~and~~, technical, and related changes.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: $\frac{2}{3}$. Appropriation: no. Fiscal committee: yes.

State-mandated local program: ~~no~~-yes.

The people of the State of California do enact as follows:

1 *SECTION 1. Section 1350.1 is added to the Health and Safety*
2 *Code, to read:*

3 1350.1. (a) *A health care service plan that arranges directly*
4 *or indirectly to provide health care services in this state under the*
5 *Medicare Advantage program pursuant to Part C (commencing*
6 *with Section 1395w-21) of Title XVIII of Chapter 7 of Title 42 of*
7 *the United States Code shall be licensed under this chapter and*
8 *shall comply with all requirements under this chapter except to*
9 *the extent preempted by federal law.*

10 (b) *Any arrangement for health care services other than that*
11 *specified in subdivision (a) shall comply with all of the*
12 *requirements of this chapter to the extent applicable.*

13 *SEC. 2. Section 1358.4 of the Health and Safety Code is*
14 *amended to read:*

15 1358.4. The following definitions apply for the purposes of
16 this article:

17 (a) “Applicant” means:

18 (1) An individual enrollee who seeks to contract for health
19 coverage, in the case of an individual Medicare supplement
20 contract.

21 (2) An enrollee who seeks to obtain health coverage through a
22 group, in the case of a group Medicare supplement contract.

23 (b) “Bankruptcy” means that situation in which a Medicare
24 Advantage organization that is not an issuer has filed, or has had
25 filed against it, a petition for declaration of bankruptcy and has
26 ceased doing business in the state.

27 (c) “Continuous period of creditable coverage” means the period
28 during which an individual was covered by creditable coverage,
29 if during the period of the coverage the individual had no breaks
30 in coverage greater than 63 days.

31 (d) (1) “Creditable coverage” means, with respect to an
32 individual, coverage of the individual provided under any of the
33 following:

34 (A) Any individual or group contract, policy, certificate, or
35 program that is written or administered by a health care service
36 plan, health insurer, fraternal benefits society, self-insured
37 employer plan, or any other entity, in this state or elsewhere, and
38 that arranges or provides medical, hospital, and surgical coverage

1 not designed to supplement other private or governmental plans.

2 The term includes continuation or conversion coverage.

3 (B) Part A or B of Title XVIII of the federal Social Security
4 Act (Medicare).

5 (C) Title XIX of the federal Social Security Act (medicaid),
6 other than coverage consisting solely of benefits under Section
7 1928 of that act.

8 (D) Chapter 55 of Title 10 of the United States Code
9 (CHAMPUS).

10 (E) A medical care program of the Indian Health Service or of
11 a tribal organization.

12 (F) A state health benefits risk pool.

13 (G) A health plan offered under Chapter 89 of Title 5 of the
14 United States Code (Federal Employees Health Benefits Program).

15 (H) A public health plan as defined in federal regulations
16 authorized by Section 2701(c)(1)(I) of the federal Public Health
17 Service Act, as amended by Public Law 104-191, the federal Health
18 Insurance Portability and Accountability Act of 1996.

19 (I) A health benefit plan under Section 5(e) of the federal Peace
20 Corps Act (Section 2504(e) of Title 22 of the United States Code).

21 (J) Any other publicly sponsored program, provided in this state
22 or elsewhere, of medical, hospital, and surgical care.

23 (K) Any other creditable coverage as defined by subsection (c)
24 of Section 2701 of Title XXVII of the federal Public Health
25 Services Act (42 U.S.C. Sec. 300gg(c)).

26 (2) "Creditable coverage" shall not include one or more, or any
27 combination of, the following:

28 (A) Coverage for accident-only or disability income insurance,
29 or any combination thereof.

30 (B) Coverage issued as a supplement to liability insurance.

31 (C) Liability insurance, including general liability insurance
32 and automobile liability insurance.

33 (D) Workers' compensation or similar insurance.

34 (E) Automobile medical payment insurance.

35 (F) Credit-only insurance.

36 (G) Coverage for onsite medical clinics.

37 (H) Other similar insurance coverage, specified in federal
38 regulations, under which benefits for medical care are secondary
39 or incidental to other insurance benefits.

(3) “Creditable coverage” shall not include the following benefits if they are provided under a separate policy, certificate, or contract or are otherwise not an integral part of the plan:

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Other similar, limited benefits as are specified in federal regulations.

(4) “Creditable coverage” shall not include the following benefits if offered as independent, noncoordinated benefits:

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(5) “Creditable coverage” shall not include the following if offered as a separate policy, certificate, or contract:

(A) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the federal Social Security Act.

(B) Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code.

(C) Similar supplemental coverage provided to coverage under a group health plan.

(e) “Employee welfare benefit plan” means a plan, fund, or program of employee benefits as defined in Section 1002 of Title 29 of the United States Code (Employee Retirement Income Security Act).

(f) “Insolvency” means when an issuer, licensed to transact the business of a health care service plan in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer’s state of domicile.

(g) “Issuer” means a health care service plan delivering, or issuing for delivery, Medicare supplement contracts in this state, but does not include entities subject to Article 6 (commencing with Section 10192.1) of Chapter 1 of Division 2 of the Insurance Code.

(h) “Medicare” means the federal Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

(i) “Medicare Advantage Plan” means a plan of coverage for health benefits under Medicare Part C and includes:

(1) Coordinated care plans that provide health care services, including, but not limited to, health care service plans (with or without a point-of-service option), plans offered by

1 provider-sponsored organizations, and preferred provider
2 organizations plans.

3 (2) Medical savings account plans coupled with a contribution
4 into a Medicare Advantage medical savings account.

5 (3) Medicare Advantage private fee-for-service plans.

6 (j) “Medicare supplement contract” means a group or individual
7 plan contract of hospital and medical service associations or health
8 care service plans, other than a contract issued pursuant to a
9 contract under Section 1876 of the federal Social Security Act (42
10 U.S.C.A. Section 1395mm) or an issued contract under a
11 demonstration project specified in Section 1395ss(g)(1) of Title
12 42 of the United States Code, that is advertised, marketed, or
13 designed primarily as a supplement to reimbursements under
14 Medicare for the hospital, medical, or surgical expenses of persons
15 eligible for Medicare. “Contract” means “Medicare supplement
16 contract,” unless the context requires otherwise. “Medicare
17 supplement contract” does not include a Medicare Advantage plan
18 established under Medicare Part C, an outpatient prescription drug
19 plan established under Medicare Part D, or a health care
20 prepayment plan that provides benefits pursuant to an agreement
21 under subparagraph (A) of paragraph (1) of subsection (a) of
22 Section 1833 of the Social Security Act.

23 (k) *“Prestandardized Medicare supplement benefit plan,”*
24 *“prestandardized benefit plan,” or “prestandardized plan” means*
25 *a group or individual Medicare supplement contract issued prior*
26 *to July 21, 1992.*

27 (l) *“1990 standardized Medicare supplement benefit plan,”*
28 *“1990 standardized benefit plan,” or “1990 plan” means a group*
29 *or individual Medicare supplement contract issued on or after*
30 *July 21, 1992, and with an effective date prior to June 1, 2010,*
31 *and includes Medicare supplement contracts renewed on or after*
32 *that date which are not replaced by the issuer at the request of the*
33 *enrollee or subscriber.*

34 (m) *“2010 standardized Medicare supplement benefit plan,”*
35 *“2010 standardized benefit plan,” or “2010 plan” means a group*
36 *or individual Medicare supplement contract issued with an effective*
37 *date on or after June 1, 2010.*

38 ~~(k)~~

39 (n) “Secretary” means the Secretary of the United States
40 Department of Health and Human Services.

1 *SEC. 3. Section 1358.6 of the Health and Safety Code is*
2 *amended to read:*

3 1358.6. (a) (1) Except for permitted preexisting condition
4 clauses as described in Sections 1358.7~~and~~, 1358.8, *and 1358.81*,
5 a contract shall not be advertised, solicited, or issued for delivery
6 as a Medicare supplement contract if the contract contains
7 definitions, limitations, exclusions, conditions, reductions, or other
8 provisions that are more restrictive or limiting than that term as
9 officially used in Medicare, except as expressly authorized by this
10 article.

11 (2) No issuer may advertise, solicit, or issue for delivery any
12 Medicare supplement contract with hospital or medical coverage
13 if the contract contains any of the prohibited provisions described
14 in subdivision (b).

15 (b) The following provisions shall be deemed to be unfair,
16 unreasonable, and inconsistent with the objectives of this chapter
17 and shall not be contained in any Medicare supplement contract:

18 (1) Any waiver, exclusion, limitation, or reduction based on or
19 relating to a preexisting disease or physical condition, unless that
20 waiver, exclusion, limitation, or reduction (A) applies only to
21 coverage for specified services rendered not more than six months
22 from the effective date of coverage, (B) is based on or relates only
23 to a preexisting disease or physical condition defined no more
24 restrictively than a condition for which medical advice was given
25 or treatment was recommended by or received from a physician
26 within six months before the effective date of coverage, (C) does
27 not apply to any coverage under any group contract, and (D) is
28 approved in advance by the director. Any limitations with respect
29 to a preexisting condition shall appear as a separate paragraph of
30 the contract and be labeled "Preexisting Condition Limitations."

31 (2) Except with respect to a group contract subject to, and in
32 compliance with, Section 1399.62, any provision denying coverage,
33 after termination of the contract, for services provided continuously
34 beginning while the contract was in effect, during the continuous
35 total disability of the subscriber or enrollee, except that the
36 coverage may be limited to a reasonable period of time not less
37 than the duration of the contract benefit period, if any, and may
38 be limited to the maximum benefits provided under the contract.

39 (c) A Medicare supplement contract in force shall not contain
40 benefits that duplicate benefits provided by Medicare.

1 (d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of
2 Section 1358.8, a Medicare supplement contract with benefits for
3 outpatient prescription drugs that was issued prior to January 1,
4 2006, shall be renewed for current enrollees and subscribers, at
5 their option, who do not enroll in Medicare Part D.

6 (2) A Medicare supplement contract with benefits for outpatient
7 prescription drugs shall not be issued on and after January 1, 2006.

8 (3) On and after January 1, 2006, a Medicare supplement
9 contract with benefits for outpatient prescription drugs shall not
10 be renewed after the enrollee or subscriber enrolls in Medicare
11 Part D unless both of the following conditions exist:

12 (A) The contract is modified to eliminate outpatient prescription
13 drug coverage for outpatient prescription drug expenses incurred
14 after the effective date of the individual's coverage under a
15 Medicare Part D plan.

16 (B) The premium is adjusted to reflect the elimination of
17 outpatient prescription drug coverage at the time of enrollment in
18 Medicare Part D, accounting for any claims paid if applicable.

19 *SEC. 4. Section 1358.8 of the Health and Safety Code is*
20 *amended to read:*

21 1358.8. The following standards are applicable to all Medicare
22 supplement contracts advertised, solicited, or issued for delivery
23 on or after January 1, 2001, *and with an effective date prior to*
24 *June 1, 2010.* A contract shall not be advertised, solicited, or issued
25 for delivery as a Medicare supplement contract unless it complies
26 with these benefit standards.

27 (a) The following general standards apply to Medicare
28 supplement contracts and are in addition to all other requirements
29 of this article:

30 (1) A Medicare supplement contract shall not exclude or limit
31 benefits for losses incurred more than six months from the effective
32 date of coverage because it involved a preexisting condition. The
33 contract shall not define a preexisting condition more restrictively
34 than a condition for which medical advice was given or treatment
35 was recommended by or received from a physician within six
36 months before the effective date of coverage.

37 (2) A Medicare supplement contract shall not indemnify against
38 losses resulting from sickness on a different basis than losses
39 resulting from accidents.

1 (3) A Medicare supplement contract shall provide that benefits
2 designed to cover cost-sharing amounts under Medicare will be
3 changed automatically to coincide with any changes in the
4 applicable Medicare deductible ~~amount and copayment percentage~~
5 ~~factors~~, *copayment, or coinsurance amounts*. Prepaid or periodic
6 charges may be modified to correspond with those changes.

7 (4) A Medicare supplement contract shall not provide for
8 termination of coverage of a spouse solely because of the
9 occurrence of an event specified for termination of coverage of
10 the covered person, other than the nonpayment of the prepaid or
11 periodic charge.

12 (5) Each Medicare supplement contract shall be guaranteed
13 renewable.

14 (A) The issuer shall not cancel or nonrenew the contract solely
15 on the ground of health status of the individual.

16 (B) The issuer shall not cancel or nonrenew the contract for any
17 reason other than nonpayment of the prepaid or periodic charge
18 or misrepresentation of the risk by the applicant that is shown by
19 the plan to be material to the acceptance for coverage. The
20 contestability period for Medicare supplement contracts shall be
21 two years.

22 (C) If a group Medicare supplement contract is terminated by
23 the subscriber and is not replaced as provided under subparagraph
24 (E), the issuer shall offer enrollees an individual Medicare
25 supplement contract that, at the option of the enrollee, either
26 provides for continuation of the benefits contained in the terminated
27 contract or provides for benefits that otherwise meet the
28 requirements of this subsection.

29 (D) If an individual is an enrollee in a group Medicare
30 supplement contract and the individual membership in the group
31 is terminated, the issuer shall either offer the enrollee the
32 conversion opportunity described in subparagraph (C) or, at the
33 option of the subscriber, shall offer the enrollee continuation of
34 coverage under the group contract.

35 (E) If a group Medicare supplement contract is replaced by
36 another group Medicare supplement contract purchased by the
37 same subscriber, the issuer of the replacement contract shall offer
38 coverage to all persons covered under the old group contract on
39 its date of termination. Coverage under the new contract shall not

1 result in any exclusion for preexisting conditions that would have
2 been covered under the group contract being replaced.

3 (F) If a Medicare supplement contract eliminates an outpatient
4 prescription drug benefit as a result of requirements imposed by
5 the Medicare Prescription Drug, Improvement, and Modernization
6 Act of 2003 (~~P.L.~~ (*Public Law* 108-173), the contract as modified
7 as a result of that act shall be deemed to satisfy the guaranteed
8 renewal requirements of this paragraph.

9 (6) Termination of a Medicare supplement contract shall be
10 without prejudice to any continuous loss that commenced while
11 the contract was in force, but the extension of benefits beyond the
12 period during which the contract was in force may be predicated
13 upon the continuous total disability of the covered person, limited
14 to the duration of the contract benefit period, if any, or to payment
15 of the maximum benefits. Receipt of Medicare Part D benefits
16 shall not be considered in determining a continuous loss.

17 (7) (A) (i) A Medicare supplement contract shall provide that
18 benefits and prepaid or periodic charges under the contract shall
19 be suspended at the request of the enrollee for the period, not to
20 exceed 24 months, in which the enrollee has applied for and is
21 determined to be entitled to medical assistance under Title XIX
22 of the federal Social Security Act, but only if the enrollee notifies
23 the issuer of the contract within 90 days after the date the individual
24 becomes entitled to assistance.

25 If suspension occurs and if the enrollee loses entitlement to
26 medical assistance, the contract shall be automatically reinstituted,
27 effective as of the date of termination of entitlement, as of the
28 termination of entitlement if the enrollee provides notice of loss
29 of entitlement within 90 days after the date of loss and pays the
30 prepaid or periodic charge attributable to the period, effective as
31 of the date of termination of entitlement. *Upon receipt of timely*
32 *notice, the issuer shall return directly to the enrollee that portion*
33 *of the prepaid or periodic charge attributable to the period the*
34 *enrollee was entitled to medical assistance, subject to adjustment*
35 *for paid claims.*

36 (ii) A Medicare supplement contract shall provide that benefits
37 and premiums under the contract shall be suspended at the request
38 of the enrollee or subscriber for any period that may be provided
39 by federal regulation if the enrollee or subscriber is entitled to
40 benefits under Section 226 (b) of the Social Security Act and is

1 covered under a group health plan, as defined in Section 1862
2 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and
3 the enrollee or subscriber loses coverage under the group health
4 plan, the contract shall be automatically reinstituted, effective as
5 of the date of loss of coverage if the enrollee or subscriber provides
6 notice within 90 days of the date of the loss of coverage.

7 (B) Reinstitution of coverages:

8 (i) Shall not provide for any waiting period with respect to
9 treatment of preexisting conditions.

10 (ii) Shall provide for resumption of coverage that is substantially
11 equivalent to coverage in effect before the date of suspension. If
12 the suspended Medicare supplement contract provided coverage
13 for outpatient prescription drugs, reinstitution of the contract for
14 a Medicare Part D enrollee shall not include coverage for outpatient
15 prescription drugs but shall otherwise provide coverage that is
16 substantially equivalent to the coverage in effect before the date
17 of suspension.

18 (iii) Shall provide for classification of prepaid or periodic
19 charges on terms at least as favorable to the enrollee as the prepaid
20 or periodic charge classification terms that would have applied to
21 the enrollee had the coverage not been suspended.

22 (8) *If an issuer makes a written offer to the Medicare supplement*
23 *enrollee or subscriber of one or more of its plan contracts, to*
24 *exchange during a specified period from his or her 1990*
25 *standardized plan, as described in Section 1358.9, to a 2010*
26 *standardized plan, as described in Section 1358.91, the offer and*
27 *subsequent exchange shall comply with the following requirements:*

28 (A) *An issuer need not provide justification to the director if the*
29 *enrollee or subscriber replaces a 1990 standardized plan contract*
30 *with an issue age rated 2010 standardized plan contract at the*
31 *enrollee or subscriber's original issue age and duration. If an*
32 *enrollee or subscriber's plan contract to be replaced is priced on*
33 *an issue age rate schedule at the time of such offer, the rate*
34 *charged to the enrollee or subscriber for the new exchanged plan*
35 *shall recognize the plan contract reserve buildup, due to the*
36 *prefunding inherent in the use of an issue age rate basis, for the*
37 *benefit of the enrollee or subscriber. The method proposed to be*
38 *used by an issuer shall be filed with the director.*

1 (B) The rating class of the new plan contract shall be the class
2 closest to the enrollee or subscriber's class of the replaced
3 coverage.

4 (C) An issuer may not apply new preexisting condition
5 limitations or a new incontestability period to the new plan contract
6 for those benefits contained in the exchanged 1990 standardized
7 plan contract of the enrollee or subscriber, but may apply
8 preexisting condition limitations of no more than six months to
9 any added benefits contained in the new 2010 standardized plan
10 contract not contained in the exchanged plan contract. This
11 subdivision shall not apply to an applicant who is guaranteed issue
12 under Section 1358.11 or 1358.12.

13 (D) The new plan contract shall be offered to all enrollees or
14 subscribers within a given plan, except where the offer or issue
15 would be in violation of state or federal law.

16 ~~(8)~~

17 (9) A Medicare supplement contract shall not be limited to
18 coverage for a single disease or affliction.

19 ~~(9)~~

20 (10) A Medicare supplement contract shall provide an
21 examination period of 30 days after the receipt of the contract by
22 the applicant for purposes of review, during which time the
23 applicant may return the contract as described in subdivision (e)
24 of Section 1358.17.

25 ~~(10)~~

26 (11) A Medicare supplement contract shall additionally meet
27 any other minimum benefit standards as established by the director.

28 ~~(11)~~

29 (12) Within 30 days prior to the effective date of any Medicare
30 benefit changes, an issuer shall file with the director, and notify
31 its subscribers and enrollees of, modifications it has made to
32 Medicare supplement contracts.

33 (A) The notice shall include a description of revisions to the
34 Medicare Program and a description of each modification made
35 to the coverage provided under the Medicare supplement contract.

36 (B) The notice shall inform each subscriber and enrollee as to
37 when any adjustment in the prepaid or periodic charges will be
38 made due to changes in Medicare benefits.

39 (C) The notice of benefit modifications and any adjustments to
40 the prepaid or periodic charges shall be in outline form and in clear

1 and simple terms so as to facilitate comprehension. The notice
2 shall not contain or be accompanied by any solicitation.

3 ~~(12)~~

4 (13) No modifications to existing Medicare supplement coverage
5 shall be made at the time of, or in connection with, the notice
6 requirements of this article except to the extent necessary to
7 eliminate duplication of Medicare benefits and any modifications
8 necessary under the contract to provide indexed benefit adjustment.

9 (b) With respect to the standards for basic (core) benefits for
10 benefit plans A to J, inclusive, every issuer shall make available
11 a contract including only the following basic “core” package of
12 benefits to each prospective applicant. This “core” package of
13 benefits shall be referred to as standardized Medicare supplement
14 benefit plan “A”. An issuer may make available to prospective
15 applicants any of the other Medicare supplement insurance benefit
16 plans in addition to the basic core package, but not in lieu of it.

17 (1) Coverage of Part A Medicare eligible expenses for
18 hospitalization to the extent not covered by Medicare from the
19 61st day to the 90th day, inclusive, in any Medicare benefit period.

20 (2) Coverage of Part A Medicare eligible expenses incurred for
21 hospitalization to the extent not covered by Medicare for each
22 Medicare lifetime inpatient reserve day used.

23 (3) Upon exhaustion of the Medicare hospital inpatient coverage
24 including the lifetime reserve days, coverage of 100 percent of the
25 Medicare Part A eligible expenses for hospitalization paid at the
26 applicable prospective payment system rate or other appropriate
27 Medicare standard of payment, subject to a lifetime maximum
28 benefit of an additional 365 days. The provider shall accept the
29 issuer’s payment as payment in full and may not bill the enrollee
30 or subscriber for any balance.

31 (4) Coverage under Medicare Parts A and B for the reasonable
32 cost of the first three pints of blood, or equivalent quantities of
33 packed red blood cells, as defined under federal regulations, unless
34 replaced in accordance with federal regulations.

35 (5) Coverage for the coinsurance amount, or in the case of
36 hospital outpatient services, the copayment amount, of Medicare
37 eligible expenses under Part B regardless of hospital confinement,
38 subject to the Medicare Part B deductible.

1 (c) The following additional benefits shall be included in
2 Medicare supplement benefit plans B to J, inclusive, only as
3 provided by Section 1358.9.

4 (1) With respect to the Medicare Part A deductible, coverage
5 for all of the Medicare Part A inpatient hospital deductible amount
6 per benefit period.

7 (2) With respect to skilled nursing facility care, coverage for
8 the actual billed charges up to the coinsurance amount from the
9 21st day to the 100th day, inclusive, in a Medicare benefit period
10 for posthospital skilled nursing facility care eligible under Medicare
11 Part A.

12 (3) With respect to the Medicare Part B deductible, coverage
13 for all of the Medicare Part B deductible amount per calendar year
14 regardless of hospital confinement.

15 (4) With respect to 80 percent of the Medicare Part B excess
16 charges, coverage for 80 percent of the difference between the
17 actual Medicare Part B charge as billed, not to exceed any charge
18 limitation established by the Medicare Program or state law, and
19 the Medicare-approved Part B charge.

20 (5) With respect to 100 percent of the Medicare Part B excess
21 charges, coverage for all of the difference between the actual
22 Medicare Part B charge as billed, not to exceed any charge
23 limitation established by the Medicare Program or state law, and
24 the Medicare-approved Part B charge.

25 (6) With respect to the basic outpatient prescription drug benefit,
26 coverage for 50 percent of outpatient prescription drug charges,
27 after a two-hundred-fifty-dollar (\$250) calendar year deductible,
28 to a maximum of one thousand two hundred fifty dollars (\$1,250)
29 in benefits received by the insured per calendar year, to the extent
30 not covered by Medicare. On and after January 1, 2006, no
31 Medicare supplement contract may be sold or issued if it includes
32 a prescription drug benefit.

33 (7) With respect to the extended outpatient prescription drug
34 benefit, coverage for 50 percent of outpatient prescription drug
35 charges, after a two-hundred-fifty-dollar (\$250) calendar year
36 deductible, to a maximum of three thousand dollars (\$3,000) in
37 benefits received by the insured per calendar year, to the extent
38 not covered by Medicare. On and after January 1, 2006, no
39 Medicare supplement contract may be sold or issued if it includes
40 a prescription drug benefit.

1 (8) With respect to medically necessary emergency care in a
2 foreign country, coverage to the extent not covered by Medicare
3 for 80 percent of the billed charges for Medicare-eligible expenses
4 for medically necessary emergency hospital, physician, and medical
5 care received in a foreign country, which care would have been
6 covered by Medicare if provided in the United States and which
7 care began during the first 60 consecutive days of each trip outside
8 the United States, subject to a calendar year deductible of two
9 hundred fifty dollars (\$250), and a lifetime maximum benefit of
10 fifty thousand dollars (\$50,000). For purposes of this benefit,
11 “emergency care” shall mean care needed immediately because
12 of an injury or an illness of sudden and unexpected onset.

13 (9) With respect to the preventive medical care benefit, coverage
14 for the following preventive health services:

15 (A) An annual clinical preventive medical history and physical
16 examination that may include tests and services from subparagraph
17 (B) and patient education to address preventive health care
18 measures.

19 (B) The following screening tests or preventive services that
20 are not covered by Medicare, the selection and frequency of which
21 are determined to be medically appropriate by the attending
22 physician:

23 (i) Fecal occult blood test.

24 (ii) Mammogram.

25 (C) Influenza vaccine administered at any appropriate time
26 during the year.

27 Reimbursement shall be for the actual charges up to 100 percent
28 of the Medicare-approved amount for each service, as if Medicare
29 were to cover the service as identified in American Medical
30 Association Current Procedural Terminology (AMACPT) codes,
31 to a maximum of one hundred twenty dollars (\$120) annually
32 under this benefit. This benefit shall not include payment for any
33 procedure covered by Medicare.

34 (10) With respect to the at-home recovery benefit, coverage for
35 services to provide short-term, at-home assistance with activities
36 of daily living for those recovering from an illness, injury, or
37 surgery.

38 (A) For purposes of this benefit, the following definitions shall
39 apply:

1 (i) “Activities of daily living” include, but are not limited to,
2 bathing, dressing, personal hygiene, transferring, eating,
3 ambulating, assistance with drugs that are normally
4 self-administered, and changing bandages or other dressings.

5 (ii) “Care provider” means a duly qualified or licensed home
6 health aide or homemaker, or a personal care aide or nurse provided
7 through a licensed home health care agency or referred by a
8 licensed referral agency or licensed nurses registry.

9 (iii) “Home” shall mean any place used by the insured as a place
10 of residence, provided that the place would qualify as a residence
11 for home health care services covered by Medicare. A hospital or
12 skilled nursing facility shall not be considered the insured’s place
13 of residence.

14 (iv) “At-home recovery visit” means the period of a visit
15 required to provide at-home recovery care, without any limit on
16 the duration of the visit, except that each consecutive four hours
17 in a 24-hour period of services provided by a care provider is one
18 visit.

19 (B) With respect to coverage requirements and limitations, the
20 following shall apply:

21 (i) At-home recovery services provided shall be primarily
22 services that assist in activities of daily living.

23 (ii) The covered person’s attending physician shall certify that
24 the specific type and frequency of at-home recovery services are
25 necessary because of a condition for which a home care plan of
26 treatment was approved by Medicare.

27 (iii) Coverage is limited to the following:

28 (I) No more than the number and type of at-home recovery visits
29 certified as necessary by the covered person’s attending physician.
30 The total number of at-home recovery visits shall not exceed the
31 number of Medicare-approved home health care visits under a
32 Medicare-approved home care plan of treatment.

33 (II) The actual charges for each visit up to a maximum
34 reimbursement of forty dollars (\$40) per visit.

35 (III) One thousand six hundred dollars (\$1,600) per calendar
36 year.

37 (IV) Seven visits in any one week.

38 (V) Care furnished on a visiting basis in the insured’s home.

39 (VI) Services provided by a care provider as defined in
40 subparagraph (A).

1 (VII) At-home recovery visits while the covered person is
2 covered under the ~~policy or certificate~~ *contract* and not otherwise
3 excluded.

4 (VIII) At-home recovery visits received during the period the
5 covered person is receiving Medicare-approved home care services
6 or no more than eight weeks after the service date of the last
7 Medicare-approved home health care visit.

8 (C) Coverage is excluded for the following:

9 (i) Home care visits paid for by Medicare or other government
10 programs.

11 (ii) Care provided by family members, unpaid volunteers, or
12 providers who are not care providers.

13 (d) The standardized Medicare supplement benefit plan “K”
14 shall consist of the following benefits:

15 (1) Coverage of 100 percent of the Medicare Part A hospital
16 coinsurance amount for each day used from the 61st to the 90th
17 day, inclusive, in any Medicare benefit period.

18 (2) Coverage of 100 percent of the Medicare Part A hospital
19 coinsurance amount for each Medicare lifetime inpatient reserve
20 day used from the 91st to the 150th day, inclusive, in any Medicare
21 benefit period.

22 (3) Upon exhaustion of the Medicare hospital inpatient coverage,
23 including the lifetime reserve days, coverage of 100 percent of the
24 Medicare Part A eligible expenses for hospitalization paid at the
25 applicable prospective payment system rate, or other appropriate
26 Medicare standard of payment, subject to a lifetime maximum
27 benefit of an additional 365 days. The provider shall accept the
28 issuer’s payment for this benefit as payment in full and shall not
29 bill the enrollee or subscriber for any balance.

30 (4) With respect to the Medicare Part A deductible, coverage
31 for 50 percent of the Medicare Part A inpatient hospital deductible
32 amount per benefit period until the out-of-pocket limitation
33 described in paragraph (10) is met.

34 (5) With respect to skilled nursing facility care, coverage for
35 50 percent of the coinsurance amount for each day used from the
36 21st day to the 100th day, inclusive, in a Medicare benefit period
37 for posthospital skilled nursing facility care eligible under Medicare
38 Part A until the out-of-pocket limitation described in paragraph
39 (10) is met.

1 (6) With respect to hospice care, coverage for 50 percent of cost
2 sharing for all Medicare Part A eligible expenses and respite care
3 until the out-of-pocket limitation described in paragraph (10) is
4 met.

5 (7) Coverage for 50 percent, under Medicare Part A or B, of
6 the reasonable cost of the first three pints of blood or equivalent
7 quantities of packed red blood cells, as defined under federal
8 regulations, unless replaced in accordance with federal regulations,
9 until the out-of-pocket limitation described in paragraph (10) is
10 met.

11 (8) Except for coverage provided in paragraph (9), coverage for
12 50 percent of the cost sharing otherwise applicable under Medicare
13 Part B after the enrollee or subscriber pays the Part B deductible,
14 until the out-of-pocket limitation is met as described in paragraph
15 (10).

16 (9) Coverage of 100 percent of the cost sharing for Medicare
17 Part B preventive services, after the enrollee or subscriber pays
18 the Medicare Part B deductible.

19 (10) Coverage of 100 percent of all cost sharing under Medicare
20 Parts A and B for the balance of the calendar year after the
21 individual has reached the out-of-pocket limitation on annual
22 expenditures under Medicare Parts A and B of four thousand
23 dollars (\$4,000) in 2006, indexed each year by the appropriate
24 inflation adjustment specified by the secretary.

25 (e) The standardized Medicare supplement benefit plan "L"
26 shall consist of the following benefits:

27 (1) The benefits described in paragraphs (1), (2), (3), and (9) of
28 subdivision (d).

29 (2) With respect to the Medicare Part A deductible, coverage
30 for 75 percent of the Medicare Part A inpatient hospital deductible
31 amount per benefit period until the out-of-pocket limitation
32 described in paragraph (8) is met.

33 (3) With respect to skilled nursing facility care, coverage for
34 75 percent of the coinsurance amount for each day used from the
35 21st day to the 100th day, inclusive, in a Medicare benefit period
36 for posthospital skilled nursing facility care eligible under Medicare
37 Part A until the out-of-pocket limitation described in paragraph
38 (8) is met.

(4) With respect to hospice care, coverage for 75 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation described in paragraph (8) is met.

(5) Coverage for 75 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations, until the out-of-pocket limitation described in paragraph (8) is met.

(6) Except for coverage provided in paragraph (7), coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the enrollee or subscriber pays the Part B deductible until the out-of-pocket limitation described in paragraph (8) is met.

(7) Coverage for 100 percent of the cost sharing for Medicare Part B preventive services after the enrollee or subscriber pays the Part B deductible.

(8) Coverage of 100 percent of the cost sharing for Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of two thousand dollars (\$2,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary.

(f) A contract shall not contain any provision delaying the effective date of coverage beyond the first day of the month following the date of receipt by the issuer of the applicant's properly completed application, except that the effective date of coverage may be delayed until the 65th birthday of an applicant who is to become eligible for Medicare by reason of age if the application is received any time during the three months immediately preceding the applicant's 65th birthday.

SEC. 5. Section 1358.81 is added to the Health and Safety Code, to read:

1358.81. The following standards are applicable to all Medicare supplement contracts delivered or issued for delivery in this state with an effective date on or after June 1, 2010. No contract may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement contract unless it complies with these benefit standards. No issuer may offer any 1990 standardized Medicare supplement contract for sale with an effective date on or after June 1, 2010. Benefit standards applicable to Medicare supplement contracts issued with an effective date

1 before June 1, 2010, remain subject to the requirements of Section
2 1358.8.

3 (a) The following general standards apply to Medicare
4 supplement contracts and are in addition to all other requirements
5 of this article.

6 (1) A Medicare supplement contract shall not exclude or limit
7 benefits for losses incurred more than six months from the effective
8 date of coverage because it involved a preexisting condition. The
9 contract shall not define a preexisting condition more restrictively
10 than a condition for which medical advice was given or treatment
11 was recommended by or received from a physician within six
12 months before the effective date of coverage.

13 (2) A Medicare supplement contract shall not indemnify against
14 losses resulting from sickness on a different basis than losses
15 resulting from accidents.

16 (3) A Medicare supplement contract shall provide that benefits
17 designed to cover cost-sharing amounts under Medicare will be
18 changed automatically to coincide with any changes in the
19 applicable Medicare deductible, copayment, or coinsurance
20 amounts. Prepaid or periodic charges may be modified to
21 correspond with those changes.

22 (4) A Medicare supplement contract shall not provide for
23 termination of coverage of a spouse solely because of the
24 occurrence of an event specified for termination of coverage of
25 the enrollee or subscriber, other than the nonpayment of prepaid
26 or periodic charges.

27 (5) Each Medicare supplement contract shall be guaranteed
28 renewable.

29 (A) The issuer shall not cancel or nonrenew the contract solely
30 on the ground of health status of the individual.

31 (B) The issuer shall not cancel or nonrenew the contract for
32 any reason other than nonpayment of prepaid or periodic charges
33 or material misrepresentation.

34 (C) If the Medicare supplement contract is terminated by the
35 master policyholder and is not replaced as provided under
36 subparagraph (E), the issuer shall offer enrollees or subscribers
37 an individual Medicare supplement contract which, at the option
38 of the enrollee or subscriber, does one of the following:

39 (i) Provides for continuation of the benefits contained in the
40 group contract.

1 (ii) Provides for benefits that otherwise meet the requirements
2 of one of the standardized contracts defined in this article.

3 (D) If an individual is an enrollee or subscriber in a group
4 Medicare supplement contract and the individual terminates
5 membership in the group, the issuer shall do one of the following:

6 (i) Offer the enrollee or subscriber the conversion opportunity
7 described in subparagraph (C).

8 (ii) At the option of the group contract holder, offer the enrollee
9 or subscriber continuation of coverage under the group contract.

10 (E) (i) If a group Medicare supplement contract is replaced by
11 another group Medicare supplement contract purchased by the
12 same group contractholder, the issuer of the replacement contract
13 shall offer coverage to all persons covered under the old group
14 contract on its date of termination. Coverage under the new
15 contract shall not result in any exclusion for preexisting conditions
16 that would have been covered under the group contract being
17 replaced.

18 (ii) If a Medicare supplement contract replaces another
19 Medicare supplement contract that has been in force for six months
20 or more, the replacing issuer shall not impose an exclusion or
21 limitation based on a preexisting condition. If the original coverage
22 has been in force for less than six months, the replacing issuer
23 shall waive any time period applicable to preexisting conditions,
24 waiting periods, elimination periods, or probationary periods in
25 the new contract to the extent the time was spent under the original
26 coverage.

27 (6) Termination of a Medicare supplement contract shall be
28 without prejudice to any continuous loss which commenced while
29 the contract was in force, but the extension of benefits beyond the
30 period during which the contract was in force may be predicated
31 upon the continuous total disability of the enrollee or subscriber,
32 limited to the duration of the contract benefit period, if any, or
33 payment of the maximum benefits. Receipt of Medicare Part D
34 benefits shall not be considered in determining a continuous loss.

35 (7) (A) (i) A Medicare supplement contract shall provide that
36 benefits and prepaid or periodic charges under the contract shall
37 be suspended at the request of the enrollee or subscriber for the
38 period, not to exceed 24 months, in which the enrollee or
39 subscriber has applied for and is determined to be entitled to
40 medical assistance under Medi-Cal under Title XIX of the federal

1 *Social Security Act, but only if the enrollee or subscriber notifies*
2 *the issuer of the contract within 90 days after the date the*
3 *individual becomes entitled to assistance. Upon receipt of timely*
4 *notice, the insurer shall return directly to the enrollee or subscriber*
5 *that portion of the prepaid or periodic charge attributable to the*
6 *period of Medi-Cal eligibility, subject to adjustment for paid*
7 *claims.*

8 *(ii) If suspension occurs and if the enrollee or subscriber loses*
9 *entitlement to medical assistance under Medi-Cal, the Medicare*
10 *supplement contract shall be automatically reinstituted, effective*
11 *as of the date of termination of entitlement, as of the termination*
12 *of entitlement if the enrollee or subscriber provides notice of loss*
13 *of entitlement within 90 days after the date of loss and pays the*
14 *prepaid or periodic charge attributable to the period, effective as*
15 *of the date of termination of entitlement or equivalent coverage*
16 *shall be provided if the prior contract is no longer available.*

17 *(iii) Each Medicare supplement contract shall provide that*
18 *benefits and prepaid or periodic charges under the contract shall*
19 *be suspended (for any period that may be provided by federal*
20 *regulation) at the request of the enrollee or subscriber if the*
21 *enrollee or subscriber is entitled to benefits under Section 226 (b)*
22 *of the Social Security Act and is covered under a group health*
23 *plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security*
24 *Act). If suspension occurs and if the enrollee or subscriber loses*
25 *coverage under the group health plan, the contract shall be*
26 *automatically reinstituted (effective as of the date of loss of*
27 *coverage) if the enrollee or subscriber provides notice of loss of*
28 *coverage within 90 days after the date of the loss and pays the*
29 *applicable prepaid or periodic charge.*

30 *(B) Reinstitution of coverages shall comply with all of the*
31 *following requirements:*

32 *(i) Not provide for any waiting period with respect to treatment*
33 *of preexisting conditions.*

34 *(ii) Provide for resumption of coverage that is substantially*
35 *equivalent to coverage in effect before the date of suspension.*

36 *(iii) Provide for classification of prepaid or periodic charges*
37 *on terms at least as favorable to the enrollee or subscriber as the*
38 *classification of the prepaid or periodic charge that would have*
39 *applied to the enrollee or subscriber had the coverage not been*
40 *suspended.*

(b) With respect to the standards for basic (core) benefits for benefit plans A, B, C, D, F, F with high deductible, G, M, and N, every issuer of Medicare supplement benefit plans shall make available a contract including only the following basic “core” package of benefits to each prospective enrollee or subscriber. An issuer may make available to prospective enrollees or subscribers any of the other Medicare supplement benefit plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day, inclusive, in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the insured for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(6) Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(c) The following additional benefits shall be included in Medicare supplement benefit plans B, C, D, F, F with high deductible, G, M, and N, as provided in Section 1358.91:

(1) With respect to the Medicare Part A deductible, coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

1 (2) *With respect to the Medicare Part A deductible, coverage*
2 *for 50 percent of the Medicare Part A inpatient hospital deductible*
3 *amount per benefit period.*

4 (3) *With respect to skilled nursing facility care, coverage for*
5 *the actual billed charges up to the coinsurance amount from the*
6 *21st day through the 100th day in a Medicare benefit period for*
7 *posthospital skilled nursing facility care eligible under Medicare*
8 *Part A.*

9 (4) *With respect to the Medicare Part B deductible, coverage*
10 *for 100 percent of the Medicare Part B deductible amount per*
11 *calendar year regardless of hospital confinement.*

12 (5) *With respect to 100 percent of the Medicare Part B excess*
13 *charges, coverage for all of the difference between the actual*
14 *Medicare Part B charges as billed, not to exceed any charge*
15 *limitation established by the Medicare program or state law, and*
16 *the Medicare-approved Part B charge.*

17 (6) *With respect to medically necessary emergency care in a*
18 *foreign country, coverage to the extent not covered by Medicare*
19 *for 80 percent of the billed charges for Medicare-eligible expenses*
20 *for medically necessary emergency hospital, physician, and*
21 *medical care received in a foreign country, which care would have*
22 *been covered by Medicare if provided in the United States and*
23 *which care began during the first 60 consecutive days of each trip*
24 *outside the United States, subject to a calendar year deductible of*
25 *two hundred fifty dollars (\$250), and a lifetime maximum benefit*
26 *of fifty thousand dollars (\$50,000). For purposes of this benefit,*
27 *“emergency care” shall mean care needed immediately because*
28 *of an injury or an illness of sudden and unexpected onset.*

29 SEC. 6. *Section 1358.9 of the Health and Safety Code is*
30 *amended to read:*

31 1358.9. ~~(a) An~~ *The following standards are applicable to all*
32 *Medicare supplement contracts delivered or issued for delivery in*
33 *this state on or after July 21, 1992, and with an effective date prior*
34 *to June 1, 2010.*

35 (a) *An issuer shall make available to each prospective enrollee*
36 *a contract form containing only the basic (core) benefits, as defined*
37 *in subdivision (b) of Section 1358.8.*

38 (b) *No groups, packages, or combinations of Medicare*
39 *supplement benefits other than those listed in this section shall be*

1 offered for sale in this state, except as may be permitted by
2 subdivision (f) and by Section 1358.10.

3 (c) Benefit plans shall be uniform in structure, language,
4 designation and format to the standard benefit plans A to J,
5 inclusive, listed in subdivision (e), and shall conform to the
6 definitions in Section 1358.4. Each benefit shall be structured in
7 accordance with the format provided in subdivisions (b), (c), (d),
8 and (e) of Section 1358.8 and list the benefits in the order listed
9 in subdivision (e). For purposes of this section, “structure,
10 language, and format” means style, arrangement, and overall
11 content of a benefit.

12 (d) An issuer may use, in addition to the benefit plan
13 designations required in subdivision (c), other designations to the
14 extent permitted by law.

15 (e) With respect to the makeup of benefit plans, the following
16 shall apply:

17 (1) Standardized Medicare supplement benefit plan A shall be
18 limited to the basic (core) benefit common to all benefit plans, as
19 defined in subdivision (b) of Section 1358.8.

20 (2) Standardized Medicare supplement benefit plan B shall
21 include only the following: the core benefit, plus the Medicare
22 Part A deductible as defined in paragraph (1) of subdivision (c) of
23 Section 1358.8.

24 (3) Standardized Medicare supplement benefit plan C shall
25 include only the following: the core benefit, plus the Medicare
26 Part A deductible, skilled nursing facility care, Medicare Part B
27 deductible, and medically necessary emergency care in a foreign
28 country as defined in paragraphs (1), (2), (3), and (8) of subdivision
29 (c) of Section 1358.8, respectively.

30 (4) Standardized Medicare supplement benefit plan D shall
31 include only the following: the core benefit, plus the Medicare
32 Part A deductible, skilled nursing facility care, medically necessary
33 emergency care in a foreign country, and the at-home recovery
34 benefit as defined in paragraphs (1), (2), (8), and (10) of
35 subdivision (c) of Section 1358.8, respectively.

36 (5) Standardized Medicare supplement benefit plan E shall
37 include only the following: the core benefit, plus the Medicare
38 Part A deductible, skilled nursing facility care, medically necessary
39 emergency care in a foreign country, and preventive medical care

1 as defined in paragraphs (1), (2), (8), and (9) of subdivision (c) of
2 Section 1358.8, respectively.

3 (6) Standardized Medicare supplement benefit plan F shall
4 include only the following: the core benefit, plus the Medicare
5 Part A deductible, the skilled nursing facility care, the Medicare
6 Part B deductible, 100 percent of the Medicare Part B excess
7 charges, and medically necessary emergency care in a foreign
8 country as defined in paragraphs (1), (2), (3), (5), and (8) of
9 subdivision (c) of Section 1358.8, respectively.

10 (7) Standardized Medicare supplement benefit high deductible
11 plan F shall include only the following: 100 percent of covered
12 expenses following the payment of the annual high deductible plan
13 F deductible. The covered expenses include the core benefit, plus
14 the Medicare Part A deductible, skilled nursing facility care, the
15 Medicare Part B deductible, 100 percent of the Medicare Part B
16 excess charges, and medically necessary emergency care in a
17 foreign country as defined in paragraphs (1), (2), (3), (5), and (8)
18 of subdivision (c) of Section 1358.8, respectively. The annual high
19 deductible plan F deductible shall consist of out-of-pocket
20 expenses, other than premiums, for services covered by the
21 Medicare supplement plan F policy, and shall be in addition to any
22 other specific benefit deductibles. The annual high deductible Plan
23 F deductible shall be one thousand five hundred dollars (\$1,500)
24 for 1998 and 1999, and shall be based on the calendar year, as
25 adjusted annually thereafter by the secretary to reflect the change
26 in the Consumer Price Index for all urban consumers for the
27 12-month period ending with August of the preceding year, and
28 rounded to the nearest multiple of ten dollars (\$10).

29 (8) Standardized Medicare supplement benefit plan G shall
30 include only the following: the core benefit, plus the Medicare
31 Part A deductible, skilled nursing facility care, 80 percent of the
32 Medicare Part B excess charges, medically necessary emergency
33 care in a foreign country, and the at-home recovery benefit as
34 defined in paragraphs (1), (2), (4), (8), and (10) of *subdivision (c)*
35 *of* Section 1358.8, respectively.

36 (9) Standardized Medicare supplement benefit plan H shall
37 consist of only the following: the core benefit, plus the Medicare
38 Part A deductible, skilled nursing facility care, basic outpatient
39 prescription drug benefit, and medically necessary emergency care
40 in a foreign country as defined in paragraphs (1), (2), (6), and (8)

1 of *subdivision (c)* of Section 1358.8, respectively. The outpatient
2 prescription drug benefit shall not be included in a Medicare
3 supplement contract sold on or after January 1, 2006.

4 (10) Standardized Medicare supplement benefit plan I shall
5 consist of only the following: the core benefit, plus the Medicare
6 Part A deductible, skilled nursing facility care, 100 percent of the
7 Medicare Part B excess charges, basic outpatient prescription drug
8 benefit, medically necessary emergency care in a foreign country,
9 and at-home recovery benefit as defined in paragraphs (1), (2),
10 (5), (6), (8), and (10) of subdivision (c) of Section 1358.8,
11 respectively. The outpatient prescription drug benefit shall not be
12 included in a Medicare supplement contract sold on or after January
13 1, 2006.

14 (11) Standardized Medicare supplement benefit plan J shall
15 consist of only the following: the core benefit, plus the Medicare
16 Part A deductible, skilled nursing facility care, Medicare Part B
17 deductible, 100 percent of the Medicare Part B excess charges,
18 extended outpatient prescription drug benefit, medically necessary
19 emergency care in a foreign country, preventive medical care, and
20 at-home recovery benefit as defined in paragraphs (1), (2), (3),
21 (5), (7), (8), (9), and (10) of subdivision (c) of Section 1358.8,
22 respectively. The outpatient prescription drug benefit shall not be
23 included in a Medicare supplement contract sold on or after January
24 1, 2006.

25 (12) Standardized Medicare supplement benefit high deductible
26 plan J shall consist of only the following: 100 percent of covered
27 expenses following the payment of the annual high deductible plan
28 J deductible. The covered expenses include the core benefit, plus
29 the Medicare Part A deductible, skilled nursing facility care,
30 Medicare Part B deductible, 100 percent of the Medicare Part B
31 excess charges, extended outpatient prescription drug benefit,
32 medically necessary emergency care in a foreign country,
33 preventive medical care benefit, and at-home recovery benefit as
34 defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of
35 subdivision (c) of Section 1358.8, respectively. The annual high
36 deductible plan J deductible shall consist of out-of-pocket expenses,
37 other than premiums, for services covered by the Medicare
38 supplement plan J policy, and shall be in addition to any other
39 specific benefit deductibles. The annual deductible shall be one
40 thousand five hundred dollars (\$1,500) for 1998 and 1999, and

1 shall be based on a calendar year, as adjusted annually thereafter
2 by the secretary to reflect the change in the Consumer Price Index
3 for all urban consumers for the 12-month period ending with
4 August of the preceding year, and rounded to the nearest multiple
5 of ten dollars (\$10). The outpatient prescription drug benefit shall
6 not be included in a Medicare supplement contract sold on or after
7 January 1, 2006.

8 (13) Standardized Medicare supplement benefit plan K shall
9 consist of only those benefits described in subdivision (d) of
10 Section 1358.8.

11 (14) Standardized Medicare supplement benefit plan L shall
12 consist of only those benefits described in subdivision (e) of
13 Section 1358.8.

14 (f) An issuer may, with the prior approval of the director, offer
15 contracts with new or innovative benefits in addition to the benefits
16 provided in a contract that otherwise complies with the applicable
17 standards. The new or innovative benefits may include benefits
18 that are appropriate to Medicare supplement contracts, that are not
19 otherwise available and that are cost-effective and offered in a
20 manner that is consistent with the goal of simplification of
21 Medicare supplement contracts. On and after January 1, 2006, the
22 innovative benefit shall not include an outpatient prescription drug
23 benefit.

24 *SEC. 7. Section 1358.91 is added to the Health and Safety*
25 *Code, to read:*

26 *1358.91. The following standards are applicable to all*
27 *Medicare supplement contracts delivered or issued for delivery in*
28 *this state with an effective date on or after June 1, 2010. No*
29 *contract may be advertised, solicited, delivered, or issued for*
30 *delivery in this state as a Medicare supplement contract unless it*
31 *complies with these benefit plan standards. Benefit plan standards*
32 *applicable to Medicare supplement contracts issued with an*
33 *effective date before June 1, 2010, remain subject to the*
34 *requirements of Section 1358.9.*

35 (a) (1) *An issuer shall make available to each prospective*
36 *enrollee and subscriber a contract containing only the basic (core)*
37 *benefits, as defined in subdivision (b) of Section 1358.81.*

38 (2) *If an issuer makes available any of the additional benefits*
39 *described in subdivision (c) of Section 1358.81, or offers*
40 *standardized benefit plans K or L, as described in paragraphs (8)*

1 and (9) of subdivision (e), then the issuer shall make available to
2 each prospective enrollee and subscriber, in addition to a contract
3 with only the basic (core) benefits as described in paragraph (1),
4 a contract containing either standardized benefit plan C, as
5 described in paragraph (3) of subdivision (e), or standardized
6 benefit plan F, as described in paragraph (5) of subdivision (e).

7 (b) No groups, packages or combinations of Medicare
8 supplement benefits other than those listed in this section shall be
9 offered for sale in this state, except as may be permitted in
10 subdivision (f) and by Section 1358.10.

11 (c) Benefit plans shall be uniform in structure, language,
12 designation, and format to the standard benefit plans listed in
13 subdivision (e) and conform to the definitions in Section 1358.4.
14 Each benefit shall be structured in accordance with the format
15 provided in subdivisions (b) and (c) of Section 1358.81; or, in the
16 case of plans K or L, in paragraphs (8) or (9) of subdivision (e)
17 of Section 1358.91 and list the benefits in the order shown in
18 subdivision (e). For purposes of this section, “structure, language,
19 and format” means style, arrangement, and overall content of a
20 benefit.

21 (d) In addition to the benefit plan designations required in
22 subdivision (c), an issuer may use other designations to the extent
23 permitted by law.

24 (e) With respect to the make-up of 2010 standardized benefit
25 plans, the following shall apply:

26 (1) Standardized Medicare supplement benefit plan A shall
27 include only the following: the basic (core) benefits as defined in
28 subdivision (b) of Section 1358.81.

29 (2) Standardized Medicare supplement benefit plan B shall
30 include only the following: the basic (core) benefit as defined in
31 subdivision (b) of Section 1358.81, plus 100 percent of the
32 Medicare Part A deductible as defined in paragraph (1) of
33 subdivision (c) of Section 1358.81.

34 (3) Standardized Medicare supplement benefit plan C shall
35 include only the following: the basic (core) benefit as defined in
36 subdivision (b) of Section 1358.81, plus 100 percent of the
37 Medicare Part A deductible, skilled nursing facility care, 100
38 percent of the Medicare Part B deductible, and medically necessary
39 emergency care in a foreign country, as defined in paragraphs

1 (1), (3), (4), and (6) of subdivision (c) of Section 1358.81,
2 respectively.

3 (4) Standardized Medicare supplement benefit plan D shall
4 include only the following: the basic (core) benefit, as defined in
5 subdivision (b) of Section 1358.81, plus 100 percent of the
6 Medicare Part A deductible, skilled nursing facility care, and
7 medically necessary emergency care in an foreign country, as
8 defined in paragraphs (1), (3), and (6) of subdivision (c) of Section
9 1358.81, respectively.

10 (5) Standardized Medicare supplement plan F shall include
11 only the following: the basic (core) benefit as defined in subdivision
12 (b) of Section 1358.81, plus 100 percent of the Medicare Part A
13 deductible, skilled nursing facility care, 100 percent of the
14 Medicare Part B deductible, 100 percent of the Medicare Part B
15 excess charges, and medically necessary emergency care in a
16 foreign country, as defined in paragraphs (1), (3), (4), (5), and (6)
17 of subdivision (c) of Section 1358.81, respectively.

18 (6) Standardized Medicare supplement plan F with high
19 deductible shall include only the following: 100 percent of covered
20 expenses following the payment of the annual deductible set forth
21 in subparagraph (B).

22 (A) The basic (core) benefit as defined in subdivision (b) of
23 Section 1358.81, plus 100 percent of the Medicare Part A
24 deductible, skilled nursing facility care, 100 percent of the
25 Medicare Part B deductible, 100 percent of the Medicare Part B
26 excess charges, and medically necessary emergency care in a
27 foreign country, as defined in paragraphs (1), (3), (4), (5), and (6)
28 of subdivision (c) of Section 1358.81, respectively.

29 (B) The annual deductible in plan F with high deductible shall
30 consist of out-of-pocket expenses, other than premiums, for services
31 covered by plan F, and shall be in addition to any other specific
32 benefit deductibles. The basis for the deductible shall be one
33 thousand five hundred dollars (\$1,500) and shall be adjusted
34 annually from 1999 by the Secretary of the United States
35 Department of Health and Human Services to reflect the change
36 in the Consumer Price Index for all urban consumers for the
37 12-month period ending with August of the preceding year, and
38 rounded to the nearest multiple of ten dollars (\$10).

39 (7) Standardized Medicare supplement benefit plan G shall
40 include only the following: the basic (core) benefit as defined in

1 subdivision (b) of Section 1358.81, plus 100 percent of the
2 Medicare Part A deductible, skilled nursing facility care, 100
3 percent of the Medicare Part B excess charges, and medically
4 necessary emergency care in a foreign country, as defined in
5 paragraphs (1), (3), (5), and (6) of subdivision (c) of Section
6 1358.81, respectively.

7 (8) Standardized Medicare supplement plan K shall include
8 only the following:

9 (A) Coverage of 100 percent of the Part A hospital coinsurance
10 amount for each day used from the 61st through the 90th day in
11 any Medicare benefit period.

12 (B) Coverage of 100 percent of the Part A hospital coinsurance
13 amount for each Medicare lifetime inpatient reserve day used from
14 the 91st through the 150th day in any Medicare benefit period.

15 (C) Upon exhaustion of the Medicare hospital inpatient
16 coverage, including the lifetime reserve days, coverage of 100
17 percent of the Medicare Part A eligible expenses for hospitalization
18 paid at the applicable prospective payment system (PPS) rate, or
19 other appropriate Medicare standard of payment, subject to a
20 lifetime maximum benefit of an additional 365 days. The provider
21 shall accept the issuer's payment as payment in full and may not
22 bill the insured for any balance.

23 (D) Coverage for 50 percent of the Medicare Part A inpatient
24 hospital deductible amount per benefit period until the
25 out-of-pocket limitation is met as described in subparagraph (J).

26 (E) Coverage for 50 percent of the coinsurance amount for each
27 day used from the 21st day through the 100th day in a Medicare
28 benefit period for posthospital skilled nursing facility care eligible
29 under Medicare Part A until the out-of-pocket limitation is met as
30 described in subparagraph (J).

31 (F) Coverage for 50 percent of cost sharing for all Part A
32 Medicare eligible expenses and respite care until the out-of-pocket
33 limitation is met as described in subparagraph (J).

34 (G) Coverage for 50 percent, under Medicare Part A or B, of
35 the reasonable cost of the first three pints of blood, or equivalent
36 quantities of packed red blood cells, as defined under federal
37 regulations, unless replaced in accordance with federal regulations
38 until the out-of-pocket limitation is met as described in
39 subparagraph (J).

1 (H) Except for coverage provided in subparagraph (I), coverage
2 for 50 percent of the cost sharing otherwise applicable under
3 Medicare Part B after the enrollee or subscriber pays the Part B
4 deductible until the out-of-pocket limitation is met as described in
5 subparagraph (J).

6 (I) Coverage of 100 percent of the cost sharing for Medicare
7 Part B preventive services after the enrollee or subscriber pays
8 the Part B deductible.

9 (J) Coverage of 100 percent of all cost sharing under Medicare
10 Parts A and B for the balance of the calendar year after the
11 individual has reached the out-of-pocket limitation on annual
12 expenditures under Medicare Parts A and B of four thousand
13 dollars (\$4,000) in 2006, indexed each year by the appropriate
14 inflation adjustment specified by the Secretary of the United States
15 Department of Health and Human Services.

16 (9) Standardized Medicare supplement plan L shall include only
17 the following:

18 (A) The benefits described in subparagraphs (A), (B), (C), and
19 (I) of paragraph (8).

20 (B) The benefit described in subparagraphs (D), (E), (F), (G),
21 and (H) of paragraph (8), but substituting 75 percent for 50
22 percent.

23 (C) The benefit described in subparagraph (J) of paragraph
24 (8), but substituting two thousand dollars (\$2,000) for four
25 thousand dollars (\$4,000).

26 (10) Standardized Medicare supplement plan M shall include
27 only the following: the basic (core) benefit as defined in subdivision
28 (b) of Section 1358.81, plus 50 percent of the Medicare Part A
29 deductible, skilled nursing facility care, and medically necessary
30 emergency care in a foreign country, as defined in paragraphs
31 (2), (3), and (6) of subdivision (c) of Section 1358.81, respectively.

32 (11) Standardized Medicare supplement plan N shall include
33 only the following: the basic (core) benefit as defined in subdivision
34 (b) of Section 1358.81, plus 100 percent of the Medicare Part A
35 deductible, skilled nursing facility care, and medically necessary
36 emergency care in a foreign country, as defined in paragraphs
37 (1), (3), and (6) of subdivision (c) of Section 1358.81, respectively,
38 with copayments in the following amounts:

1 (A) *The lesser of twenty dollars (\$20) or the Medicare Part B*
2 *coinsurance or copayment for each covered health care provider*
3 *office visit, including visits to medical specialists.*

4 (B) *The lesser of fifty dollars (\$50) or the Medicare Part B*
5 *coinsurance or copayment for each covered emergency room visit;*
6 *however, this copayment shall be waived if the enrollee or*
7 *subscriber is admitted to any hospital and the emergency visit is*
8 *subsequently covered as a Medicare Part A expense.*

9 (f) *An issuer may, with the prior approval of the director, offer*
10 *contracts with new or innovative benefits, in addition to the*
11 *standardized benefits provided in a contract that otherwise*
12 *complies with the applicable standards. The new or innovative*
13 *benefits shall include only benefits that are appropriate to*
14 *Medicare supplement contracts, are new or innovative, are not*
15 *otherwise available, and are cost effective. Approval of new or*
16 *innovative benefits shall not adversely impact the goal of Medicare*
17 *supplement simplification. New or innovative benefits shall not*
18 *include an outpatient prescription drug benefit. New or innovative*
19 *benefits shall not be used to change or reduce benefits, including*
20 *a change of any cost-sharing provision, in any standardized plan.*

21 *SEC. 8. Section 1358.11 of the Health and Safety Code is*
22 *amended to read:*

23 1358.11. (a) (1) *An issuer shall not deny or condition the*
24 *offering or effectiveness of any Medicare supplement contract*
25 *available for sale in this state, nor discriminate in the pricing of a*
26 *contract because of the health status, claims experience, receipt of*
27 *health care, or medical condition of an applicant in the case of an*
28 *application for a contract that is submitted prior to or during the*
29 *six-month period beginning with the first day of the first month*
30 *in which an individual is both 65 years of age or older and is*
31 *enrolled for benefits under Medicare Part B. Each Medicare*
32 *supplement contract currently available from an issuer shall be*
33 *made available to all applicants who qualify under this subdivision*
34 *and who are 65 years of age or older.*

35 (2) *An issuer shall make available Medicare supplement benefit*
36 *plans A, B, C, and F, if currently available, to an applicant who*
37 *qualifies under this subdivision who is 64 years of age or younger*
38 *and who does not have end-stage renal disease. An issuer shall*
39 *also make available to those applicants, Medicare supplement*
40 *benefit plan H, I, or J, if currently available, and commencing*

1 January 1, 2007, shall make available to them Medicare supplement
2 benefit plan K or L, if currently available. The selection among
3 Medicare supplement benefit plan H, I, or J and the selection
4 between Medicare supplement benefit plan K or L shall be made
5 at the issuer's discretion.

6 (3) This section and Section 1358.12 do not prohibit an issuer
7 in determining subscriber rates from treating applicants who are
8 under 65 years of age and are eligible for Medicare Part B as a
9 separate risk classification. *This section shall not be construed as*
10 *preventing the exclusion of benefits for preexisting conditions as*
11 *defined in paragraph (1) of subdivision (a) of Section 1358.8 or*
12 *paragraph (1) of subdivision (a) of Section 1358.81.*

13 (b) (1) If an applicant qualifies under subdivision (a) and
14 submits an application during the time period referenced in
15 subdivision (a) and, as of the date of application, has had a
16 continuous period of creditable coverage of at least six months,
17 the issuer shall not exclude benefits based on a preexisting
18 condition.

19 (2) If the applicant qualifies under subdivision (a) and submits
20 an application during the time period referenced in subdivision (a)
21 and, as of the date of application, has had a continuous period of
22 creditable coverage that is less than six months, the issuer shall
23 reduce the period of any preexisting condition exclusion by the
24 aggregate of the period of creditable coverage applicable to the
25 applicant as of the enrollment date. The manner of the reduction
26 under this subdivision shall be as specified by the director.

27 (c) Except as provided in subdivision (b) and Section 1358.23,
28 subdivision (a) shall not be construed as preventing the exclusion
29 of benefits under a contract, during the first six months, based on
30 a preexisting condition for which the enrollee received treatment
31 or was otherwise diagnosed during the six months before the
32 coverage became effective.

33 (d) An individual enrolled in Medicare by reason of disability
34 shall be entitled to open enrollment described in this section for
35 six months after the date of his or her enrollment in Medicare Part
36 B, or if notified retroactively of his or her eligibility for Medicare,
37 for six months following notice of eligibility. Sales during the
38 open enrollment period shall not be discouraged by any means,
39 including the altering of the commission structure.

1 (e) (1) An individual enrolled in Medicare Part B is entitled to
2 open enrollment described in this section for six months following:

3 (A) Receipt of a notice of termination or, if no notice is received,
4 the effective date of termination from any employer-sponsored
5 health plan including an employer-sponsored retiree health plan.

6 (B) Receipt of a notice of loss of eligibility due to the divorce
7 or death of a spouse or, if no notice is received, the effective date
8 of loss of eligibility due to the divorce or death of a spouse, from
9 any employer-sponsored health plan including an
10 employer-sponsored retiree health plan.

11 (C) Termination of health care services for a military retiree or
12 the retiree's Medicare eligible spouse or dependent as a result of
13 a military base closure or loss of access to health care services
14 because the base no longer offers services or because the individual
15 relocates.

16 (2) For purposes of this subdivision, "employer-sponsored retiree
17 health plan" includes any coverage for medical expenses, *including*
18 *coverage under the Consolidated Omnibus Budget Reconciliation*
19 *Act of 1985 (COBRA) and the California Continuation Benefits*
20 *Replacement Act (Cal-COBRA)*, that is directly or indirectly
21 sponsored or established by an employer for employees or retirees,
22 their spouses, dependents, or other included covered persons.

23 (f) An individual enrolled in Medicare Part B is entitled to open
24 enrollment described in this section if the individual was covered
25 under a policy, certificate, or contract providing Medicare
26 supplement coverage but that coverage terminated because the
27 individual established residence at a location not served by the
28 issuer.

29 (g) (1) An individual whose coverage was terminated by a
30 Medicare Advantage plan shall be entitled to an additional 60-day
31 open enrollment period to be added on to and run consecutively
32 after any open enrollment period authorized by federal law or
33 regulation, for any and all Medicare supplement coverage available
34 on a guaranteed basis under state and federal law or regulations
35 for persons terminated by their Medicare Advantage plan.

36 (2) Health plans that terminate Medicare enrollees shall notify
37 those enrollees in the termination notice of the additional open
38 enrollment period authorized by this subdivision. Health plan
39 notices shall inform enrollees of the opportunity to secure advice

1 and assistance from the HICAP in their area, along with the
2 toll-free telephone number for HICAP.

3 (h) An individual shall be entitled to an annual open enrollment
4 period lasting 30 days or more, commencing with the individual's
5 birthday, during which time that person may purchase any
6 Medicare supplement coverage that offers benefits equal to or
7 lesser than those provided by the previous coverage. During this
8 open enrollment period, no issuer that falls under this provision
9 shall deny or condition the issuance or effectiveness of Medicare
10 supplement coverage, nor discriminate in the pricing of coverage,
11 because of health status, claims experience, receipt of health care,
12 or medical condition of the individual if, at the time of the open
13 enrollment period, the individual is covered under another
14 Medicare supplement policy, certificate, or contract. An issuer that
15 offers Medicare supplement contracts shall notify an enrollee of
16 his or her rights under this subdivision at least 30 and no more
17 than 60 days before the beginning of the open enrollment period.

18 (i) Commencing January 1, 2007, an individual enrolled in
19 Medicare Part B is entitled to open enrollment described in this
20 section upon being notified that he or she is no longer eligible for
21 benefits, *including benefits with a share of cost*, under the Medi-Cal
22 program because of an increase in the individual's income or assets.

23 *SEC. 9. Section 1358.13 of the Health and Safety Code is*
24 *amended to read:*

25 1358.13. (a) An issuer shall comply with Section 1882(c)(3)
26 of the federal Social Security Act (as enacted by Section
27 4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act
28 of 1987 (OBRA), Public Law 100-203) by doing all of the
29 following:

30 (1) Accepting a notice from a Medicare ~~carrier~~ *Administrative*
31 *Contractor, formerly known as a fiscal intermediary or carrier*,
32 on dually assigned claims submitted by participating physicians
33 and suppliers as a claim for benefits in place of any other claim
34 form otherwise required and making a payment determination on
35 the basis of the information contained in that notice.

36 (2) Notifying the participating physician or supplier and the
37 beneficiary of the payment determination.

38 (3) Paying the participating physician or supplier directly.

39 (4) Furnishing, at the time of enrollment, each enrollee with a
40 card listing the contract name, number, and a central mailing

1 address to which notices respecting coverage from a Medicare
2 ~~carrier~~ *Administrative Contractor* may be sent.

3 (5) Paying user fees established under Section 1395u(h)(3)(B)
4 of Title 42 of the United States Code, for claim notices that are
5 transmitted electronically or otherwise.

6 (6) Providing to the secretary, at least annually, a central mailing
7 address to which all claims may be sent by Medicare ~~carriers~~
8 *Administrative Contractors*.

9 (b) Compliance with the requirements set forth in subdivision
10 (a) shall be certified on the Medicare supplement insurance
11 experience reporting form provided by the director.

12 *SEC. 10. Section 1358.17 of the Health and Safety Code is*
13 *amended to read:*

14 1358.17. (a) (1) Medicare supplement contracts shall include
15 a renewal or continuation provision. The language or specifications
16 of the provision shall be consistent with subdivision (a) of Section
17 1365 and the rules adopted thereunder. The provision shall be
18 appropriately captioned and shall appear on the first page of the
19 contract, and shall include any reservation by the issuer of the right
20 to change prepaid or periodic charges and any automatic renewal
21 increases based on the enrollee's age.

22 (2) The contract shall contain the provisions required to be set
23 forth by Section 1300.67.4 of Title 28 of the California Code of
24 Regulations.

25 (b) (1) Except for contract amendments by which the issuer
26 effectuates a request made in writing by the enrollee, exercises a
27 specifically reserved right under a Medicare supplement contract,
28 or is required to reduce or eliminate benefits to avoid duplication
29 of Medicare benefits, all amendments to a Medicare supplement
30 contract after the date of issue or upon reinstatement or renewal
31 that reduce or eliminate benefits or coverage in the contract shall
32 require a signed acceptance by the subscriber. After the date of
33 contract issue, any amendment that increases benefits or coverage
34 with a concomitant increase in prepaid or periodic charges during
35 the contract term shall be agreed to in writing signed by the
36 subscriber, unless the benefits are required by the minimum
37 standards for Medicare supplement contracts, or if the increased
38 benefits or coverage is required by law. If a separate additional
39 charge is made for benefits provided in connection with contract
40 amendments, the charge shall be set forth in the contract.

1 (2) An issuer shall not in any way reduce or eliminate any
2 benefit or coverage under a Medicare supplement contract at any
3 time after the date of entering the contract, including dates of
4 reinstatement or renewal, unless and until the change is voluntarily
5 agreed to in writing signed by the subscriber or enrollee, or is
6 required to reduce or eliminate benefits to avoid duplication of
7 Medicare benefits. The issuer shall not increase benefits or
8 coverage with a concomitant increase in prepaid or periodic charges
9 during the term of the contract unless and until the change is
10 voluntarily agreed to in writing signed by the subscriber or enrollee
11 or unless the increased benefits or coverage is required by law or
12 regulation.

13 (c) Medicare supplement contracts shall not provide for the
14 payment of benefits based on standards described as “usual and
15 customary,” “reasonable and customary,” or words of similar
16 import.

17 (d) If a Medicare supplement contract contains any limitations
18 with respect to preexisting conditions, those limitations shall appear
19 as a separate paragraph of the contract and be labeled as
20 “Preexisting Condition Limitations.”

21 (e) (1) Medicare supplement contracts shall have a notice
22 prominently printed in no less than 10-point uppercase type, on
23 the cover page of the contract or attached thereto stating that the
24 applicant shall have the right to return the contract within 30 days
25 of its receipt via regular mail, and to have any charges refunded
26 in a timely manner if, after examination of the contract, the covered
27 person is not satisfied for any reason. The return shall void the
28 contract from the beginning, and the parties shall be in the same
29 position as if no contract had been issued.

30 (2) For purposes of this section, a timely manner shall be no
31 later than 30 days after the issuer receives the returned contract.

32 (3) If the issuer fails to refund all prepaid or periodic charges
33 paid in a timely manner, then the applicant shall receive interest
34 on the paid charges at the legal rate of interest on judgments as
35 provided in Section 685.010 of the Code of Civil Procedure. The
36 interest shall be paid from the date the issuer received the returned
37 contract.

38 (f) (1) Issuers of health care service plan contracts that provide
39 hospital or medical expense coverage on an expense incurred or
40 indemnity basis to persons eligible for Medicare shall provide to

1 those applicants a guide to health insurance for people with
2 Medicare in the form developed jointly by the National Association
3 of Insurance Commissioners and the Centers for Medicare and
4 Medicaid Services and in a type size no smaller than 12-point type.
5 Delivery of the guide shall be made whether or not the contracts
6 are advertised, solicited, or issued for delivery as Medicare
7 supplement contracts as defined in this article. Except in the case
8 of direct response issuers, delivery of the guide shall be made to
9 the applicant at the time of application, and acknowledgment of
10 receipt of the guide shall be obtained by the issuer. Direct response
11 issuers shall deliver the guide to the applicant upon request, but
12 not later than at the time the contract is delivered.

13 (2) For the purposes of this section, “form” means the language,
14 format, type size, type proportional spacing, bold character, and
15 line spacing.

16 (g) As soon as practicable, but no later than 30 days prior to the
17 annual effective date of any Medicare benefit changes, an issuer
18 shall notify its enrollees and subscribers of modifications it has
19 made to Medicare supplement contracts in a format acceptable to
20 the director. The notice shall include both of the following:

21 (1) A description of revisions to the Medicare Program and a
22 description of each modification made to the coverage provided
23 under the Medicare supplement contract.

24 (2) Inform each enrollee as to when any adjustment in prepaid
25 or periodic charges is to be made due to changes in Medicare.

26 (h) The notice of benefit modifications and any adjustments of
27 prepaid or periodic charges shall be in outline form and in clear
28 and simple terms so as to facilitate comprehension.

29 (i) The notices shall not contain or be accompanied by any
30 solicitation.

31 (j) (1) Issuers shall provide an outline of coverage to all
32 applicants at the time application is presented to the prospective
33 applicant and, except for direct response policies, shall obtain an
34 acknowledgment of receipt of the outline from the applicant. If an
35 outline of coverage is provided at the time of application and the
36 Medicare supplement contract is issued on a basis which would
37 require revision of the outline, a substitute outline of coverage
38 properly describing the contract shall accompany the contract when
39 it is delivered and contain the following statement, in no less than
40 12-point type, immediately above the company name:

1
2 “NOTICE: Read this outline of coverage carefully. It is not
3 identical to the outline of coverage provided upon application and
4 the coverage originally applied for has not been issued.”
5

6 (2) The outline of coverage provided to applicants pursuant to
7 this section consists of four parts: a cover page, information about
8 prepaid or periodic charges, disclosure pages, and charts displaying
9 the features of each benefit plan offered by the issuer. The outline
10 of coverage shall be in the language and format prescribed below
11 in no less than 12-point type. All ~~benefit~~ *Medicare supplement*
12 ~~plans A-L authorized by federal law~~ shall be shown on the cover
13 page, and the plans that are offered by the issuer shall be
14 prominently identified. Information about prepaid or periodic
15 charges for plans that are offered shall be shown on the cover page
16 or immediately following the cover page and shall be prominently
17 displayed. The charge and mode shall be stated for all plans that
18 are offered to the prospective applicant. All possible charges for
19 the prospective applicant shall be illustrated.

20 (3) (A) *The following shall only apply to contracts sold for*
21 *effective dates prior to June 1, 2010:*

22 (i) *The outline of coverage shall include the items, and in the*
23 *same order, specified in the chart set forth in Section 17 of the*
24 *Model Regulation to implement the NAIC Medicare Supplement*
25 *Insurance Minimum Standards Model Act, as adopted by the*
26 *National Association of Insurance Commissioners in 2004.*

27 (ii) *The cover page shall contain the 12-plan (A-L) charts. The*
28 *plans offered by the issuer shall be clearly identified. Innovative*
29 *benefits shall be explained in a manner approved by the director.*

30 (B) *The following shall only apply to policies sold for effective*
31 *dates on or after June 1, 2010:*

32 (i) *The outline of coverage shall include the items, and in the*
33 *same order specified in the chart set forth in Section 17 of the*
34 *Model Regulation to implement the NAIC Medicare Supplement*
35 *Insurance Minimum Standards Model Act, as adopted by the*
36 *National Association of Insurance Commissioners in 2008.*

37 (ii) *The cover page shall contain all Medicare supplement plan*
38 *charts A to D, inclusive, F, F with high deductible, G, and K to N,*
39 *inclusive. The plans offered by the issuer shall be clearly identified.*

Innovative benefits shall be explained in a manner approved by the director.

The text shall read: “Medicare supplement contracts can be sold in only standard plans. This chart shows the benefits included in each plan. Every insurance company must offer Plan A. Some plans may not be available. Plans E, H, I, and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]”

~~(3)~~

(4) The disclosure pages shall be in the language and format described below in no less than 12-point type.

INFORMATION ABOUT PREPAID OR PERIODIC CHARGES

[Insert plan’s name] can only raise your charges if it raises the charge for all contracts like yours in this state. [If the charge is based on the increasing age of the enrollee, include information specifying when charges will change.]

DISCLOSURES

Use this outline to compare benefits and charges among policies. [The following additional language shall be included under “DISCLOSURES” for contracts with effective dates on or after June 1, 2010, but shall not appear after June 1, 2011]

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing the most important features of your Medicare supplement plan contract. This is not the plan contract and only the actual contract provisions will control. You must read the contract itself to understand all of the rights and duties of both you and [insert the health care service plan’s name].

1 RIGHT TO RETURN POLICY

2
3 If you find that you are not satisfied with your contract, you may
4 return it to [insert plan's address]. If you send the contract back
5 to us within 30 days after you receive it, we will treat the contract
6 as if it had never been issued and return all of your payments.

7
8 POLICY REPLACEMENT

9
10 If you are replacing other health coverage, do NOT cancel it
11 until you have actually received your new contract and are sure
12 you want to keep it.

13
14 NOTICE

15
16 This contract may not fully cover all of your medical costs.
17 Neither [insert the health care service plan's name] nor its agents
18 are connected with Medicare.

19 This outline of coverage does not give all the details of Medicare
20 coverage. Contact your local social security office or consult "The
21 Medicare Handbook" for further details and limitations applicable
22 to Medicare.

23
24 COMPLETE ANSWERS ARE VERY IMPORTANT

25
26 When you fill out the application for the new contract, be sure
27 to answer truthfully and completely all questions about your
28 medical and health history. The company may cancel your contract
29 and refuse to pay any claims if you leave out or falsify important
30 medical information. [If the contract is guaranteed issue, this
31 paragraph need not appear.] Review the application carefully before
32 you sign it. Be certain that all information has been properly
33 recorded. [The charts displaying the features of each benefit plan
34 offered by the issuer shall use the uniform format and language
35 shown in the charts set forth in Section 17 of the Model Regulation
36 to Implement the NAIC Medicare Supplement Insurance Minimum
37 Standards Model Act, as most recently adopted by the National
38 Association of Insurance Commissioners. No more than four
39 benefit plans may be shown on one chart. For purposes of

1 illustration, charts for each benefit plan are set forth below. An
2 issuer may use additional benefit plan designations on these charts.]
3 [Include an explanation of any innovative benefits on the cover
4 page and in the chart, in a manner approved by the director.]

5 (k) Notwithstanding Section 1300.63.2 of Title 28 of the
6 California Code of Regulations, no issuer shall combine the
7 evidence of coverage and disclosure form into a single document
8 relating to a contract that supplements Medicare, or is advertised
9 or represented as a supplement to Medicare, with hospital or
10 medical coverage.

11 (l) The director may adopt regulations to implement this article,
12 including, but not limited to, regulations that specify the required
13 information to be contained in the outline of coverage provided to
14 applicants pursuant to this section, including the format of tables,
15 charts, and other information.

16 (m) (1) Any health care service plan contract, other than a
17 Medicare supplement contract, a contract issued pursuant to a
18 contract under Section 1876 of the federal Social Security Act (42
19 U.S.C. Sec. 1395 et seq.), a disability income policy, or any other
20 contract identified in subdivision (b) of Section 1358.3, issued for
21 delivery in this state to persons eligible for Medicare, shall notify
22 enrollees under the contract that the contract is not a Medicare
23 supplement contract. The notice shall either be printed or attached
24 to the first page of the outline of coverage delivered to enrollees
25 under the contract, or if no outline of coverage is delivered, to the
26 first page of the contract delivered to enrollees. The notice shall
27 be in no less than 12-point type and shall contain the following
28 language:

29
30 “THIS CONTRACT IS NOT A MEDICARE SUPPLEMENT.
31 If you are eligible for Medicare, review the Guide to Health
32 Insurance for People with Medicare available from the company.”
33

34 (2) Applications provided to persons eligible for Medicare for
35 the health insurance contracts described in paragraph (1) shall
36 disclose the extent to which the contract duplicates Medicare in a
37 manner required by the director. The disclosure statement shall be
38 provided as a part of, or together with, the application for the
39 contract.

(n) A Medicare supplement contract that does not cover custodial care shall, on the cover page of the outline of coverages, contain the following statement in uppercase type: “THIS POLICY DOES NOT COVER CUSTODIAL CARE IN A SKILLED NURSING CARE FACILITY.”

(o) An issuer shall comply with all notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173).

SEC. 11. Section 1358.18 of the Health and Safety Code is amended to read:

1358.18. In the interest of full and fair disclosure, and to assure the availability of necessary consumer information to potential subscribers or enrollees not possessing a special knowledge of Medicare, health care service plans, or Medicare supplement contracts, an issuer shall comply with the following provisions:

(a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medi-Cal coverage, or another health insurance policy or certificate or plan contract in force or whether a Medicare supplement contract is intended to replace any other disability policy or certificate, or plan contract, presently in force. A supplementary application or other form to be signed by the applicant and solicitor containing those questions and statements may be used.

“(Statements)

(1) You do not need more than one Medicare supplement policy or contract.

(2) If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare supplement contract.

(4) If after purchasing this contract you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to

1 Medi-Cal or Medicaid, your suspended Medicare supplement
2 contract or if that is no longer available, a substantially equivalent
3 contract, will be reinstituted if requested within 90 days of losing
4 Medi-Cal or Medicaid eligibility. If the Medicare supplement
5 contract provided coverage for outpatient prescription drugs and
6 you enrolled in Medicare Part D while your contract was
7 suspended, the reinstituted contract will not have outpatient
8 prescription drug coverage, but will otherwise be substantially
9 equivalent to your coverage before the date of the suspension.

10 (5) If you are eligible for, and have enrolled in, a Medicare
11 supplement contract by reason of disability and you later become
12 covered by an employer or union-based group health plan, the
13 benefits and premiums under your Medicare supplement contract
14 can be suspended, if requested, while you are covered under the
15 employer or union-based group health plan. If you suspend your
16 Medicare supplement contract under these circumstances and later
17 lose your employer or union-based group health plan, your
18 suspended Medicare supplement contract or if that is no longer
19 available, a substantially equivalent contract, will be reinstituted
20 if requested within 90 days of losing your employer or union-based
21 group health plan. If the Medicare supplement contract provided
22 coverage for outpatient prescription drugs and you enrolled in
23 Medicare Part D while your contract was suspended, the
24 reinstituted contract will not have outpatient prescription drug
25 coverage, but will otherwise be substantially equivalent to your
26 coverage before the date of the suspension.

27 (6) Counseling services are available in this state to provide
28 advice concerning your purchase of Medicare supplement coverage
29 and concerning medical assistance through the Medi-Cal or
30 Medicaid Program, including benefits as a qualified Medicare
31 beneficiary (QMB) and a specified low-income Medicare
32 beneficiary (SLMB). Information regarding counseling services
33 may be obtained from the California Department of Aging.

34
35 (Questions)
36

37 If you lost or are losing other health insurance coverage and
38 received a notice from your prior insurer saying you were eligible
39 for guaranteed issue of a Medicare supplement insurance contract
40 or that you had certain rights to buy such a contract, you may be

1 guaranteed acceptance in one or more of our Medicare supplement
2 plans. Please include a copy of the notice from your prior insurer
3 with your application. PLEASE ANSWER ALL QUESTIONS.

4 [Please mark Yes or No below with an "X."]

5 To the best of your knowledge,

6 (1) (a) Did you turn 65 years of age in the last 6 months

7 Yes____ No____

8 (b) Did you enroll in Medicare Part B in the last 6 months

9 Yes____ No____

10 (c) If yes, what is the effective date _____

11 (2) Are you covered for medical assistance through California's
12 Medi-Cal program

13 NOTE TO APPLICANT: If you have a share of cost under the
14 Medi-Cal program, please answer NO to this question.

15 Yes____ No____

16 If yes,

17 (a) Will Medi-Cal pay your premiums for this Medicare
18 supplement contract

19 Yes____ No____

20 (b) Do you receive benefits from Medi-Cal OTHER THAN
21 payments toward your Medicare Part B premium

22 Yes____ No____

23 (3) (a) If you had coverage from any Medicare plan other than
24 original Medicare within the past 63 days (for example, a Medicare
25 Advantage plan or a Medicare HMO or PPO), fill in your start and
26 end dates below. If you are still covered under this plan, leave
27 "END" blank.

28 START __/__/__ END __/__/__

29 (b) If you are still covered under the Medicare plan, do you
30 intend to replace your current coverage with this new Medicare
31 supplement contract

32 Yes____ No____

33 (c) Was this your first time in this type of Medicare plan

34 Yes____ No____

35 (d) Did you drop a Medicare supplement contract to enroll in
36 the Medicare plan

37 Yes____ No____

38 (4) (a) Do you have another Medicare supplement policy or
39 certificate or contract in force

40 Yes____ No____

1 (b) If so, with what company, and what plan do you have
2 [optional for Direct Mailers]

3 Yes____ No____

4 (c) If so, do you intend to replace your current Medicare
5 supplement policy or certificate or contract with this contract

6 Yes____ No____

7 (5) Have you had coverage under any other health insurance
8 within the past 63 days (For example, an employer, union, or
9 individual plan)

10 Yes____ No____

11 (a) If so, with what companies and what kind of policy

12 _____

13 _____

14 _____

15 _____

16 (b) What are your dates of coverage under the other policy

17 START __/__/__ END __/__/__

18 (If you are still covered under the other policy, leave “END”
19 blank).

20 (b) Solicitors shall list any other health insurance policies or
21 plan contracts they have sold to the applicant as follows:

22 (1) List policies and contracts sold that are still in force.

23 (2) List policies and contracts sold in the past five years that
24 are no longer in force.

25 (c) An issuer issuing Medicare supplement contracts without a
26 solicitor or solicitor firm (a direct response issuer) shall return to
27 the applicant, upon delivery of the contract, a copy of the
28 application or supplemental forms, signed by the applicant and
29 acknowledged by the issuer.

30 (d) Upon determining that a sale will involve replacement of
31 Medicare supplement coverage, any issuer, other than a direct
32 response issuer, or its agent, shall furnish the applicant, prior to
33 issuance for delivery of the Medicare supplement contract, a notice
34 regarding replacement of Medicare supplement coverage. One
35 copy of the notice signed by the applicant and the agent, except
36 where the coverage is sold without an agent, shall be provided to
37 the applicant and an additional signed copy shall be retained by
38 the issuer. A direct response issuer shall deliver to the applicant
39 at the time of the issuance of the contract the notice regarding
40 replacement of Medicare supplement coverage.

(e) The notice required by subdivision (d) for an issuer shall be provided in substantially the following form in no less than 10-point 12-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE
ADVANTAGE

(Company name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN
THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate an existing Medicare supplement policy or contract or Medicare Advantage plan and replace it with a contract to be issued by [Plan Name]. Your contract to be issued by [Plan Name] will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or contract only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision. STATEMENT TO APPLICANT BY PLAN, SOLICITOR, SOLICITOR FIRM, OR OTHER REPRESENTATIVE:

(1) I have reviewed your current medical or health coverage. ~~The~~ *To the best of my knowledge, the* replacement of coverage involved in this transaction does not duplicate coverage, ~~to the best of my knowledge or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan.~~ The replacement contract is being purchased for the following reason (check one):__ Additional benefits. __ No change in benefits, but lower premiums or charges. __ Fewer benefits and lower premiums or charges.__ Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D.__ Disenrollment from a Medicare Advantage plan. Reasons for disenrollment:__ Other. (please specify) _____

~~(2) You may not be immediately eligible for full coverage under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present policy or contract.~~

(2) If the issuer of the Medicare supplement contract being applied for does not or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 3 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.

(3) State law provides that your replacement Medicare supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.

(4) If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

(5) Do not cancel your present Medicare supplement coverage until you have received your new contract and are sure you want to keep it.

(Signature of Solicitor, Solicitor Firm, or Other Representative)
[Typed Name and Address of Plan, Solicitor, or Solicitor Firm]

(Applicant's Signature)

(Date)

1 (f) The application form or other consumer information for
2 persons eligible for Medicare and used by an issuer shall contain
3 as an attachment a Medicare supplement buyer's guide in the form
4 approved by the director. The application or other consumer
5 information, containing as an attachment the buyer's guide, shall
6 be mailed or delivered to each applicant applying for that coverage
7 at or before the time of application and, to establish compliance
8 with this subdivision, the issuer shall obtain an acknowledgment
9 of receipt of the attached buyer's guide from each applicant. No
10 issuer shall make use of or otherwise disseminate any buyer's
11 guide that does not accurately outline current Medicare supplement
12 benefits. No issuer shall be required to provide more than one copy
13 of the buyer's guide to any applicant.

14 (g) An issuer may comply with the requirement of this section
15 in the case of group contracts by causing the subscriber (1) to
16 disseminate copies of the disclosure form containing as an
17 attachment the buyer's guide to all persons eligible under the group
18 contract at the time those persons are offered the Medicare
19 supplement plan, and (2) collecting and forwarding to the issuer
20 an acknowledgment of receipt of the disclosure form containing
21 as an attachment the buyer's guide from each enrollee.

22 (h) Commencing January 1, 2007, an issuer shall not require or
23 request health information from an applicant who is guaranteed
24 issuance of any Medicare supplement coverage or require or request
25 the applicant to sign a form required by the federal Health
26 Insurance Portability and Accountability Act of 1996. The
27 application form shall include a clear and conspicuous statement
28 that the applicant is not required to provide health information or
29 to sign a form required by the federal Health Insurance Portability
30 and Accountability Act of 1996 during a period of guaranteed
31 issuance of any Medicare supplement coverage and shall inform
32 the applicant of periods of guaranteed issuance of Medicare
33 supplement coverage. A supplementary application or other form
34 containing those statements that the applicant and solicitor are
35 required to sign may be used for this purpose. This subdivision
36 shall not prohibit an issuer from requiring proof of eligibility for
37 a guaranteed issuance of Medicare supplement coverage.

38 *SEC. 12. Section 1358.20 of the Health and Safety Code is*
39 *amended to read:*

1 1358.20. (a) An issuer, directly or through solicitors or other
2 representatives, shall do each of the following:

3 (1) Establish marketing procedures to ensure that any
4 comparison of Medicare supplement coverage by its solicitors or
5 other representatives will be fair and accurate.

6 (2) Establish marketing procedures to ensure that excessive
7 coverage is not sold or issued.

8 (3) Display prominently by type, stamp, or other appropriate
9 means, on the first page of the outline of coverage and contract,
10 the following:

11
12 “Notice to buyer: This Medicare supplement contract may not
13 cover all of your medical expenses.”

14
15 (4) Inquire and otherwise make every reasonable effort to
16 identify whether a prospective applicant for a Medicare supplement
17 contract already has health care coverage and the types and
18 amounts of that coverage.

19 (5) *Provide, on the application form for Medicare supplement*
20 *contracts, a statement that reads as follows: “A rate guide is*
21 *available that compares the policies sold by different insurers.*
22 *You can obtain a copy of this rate guide by calling the Department*
23 *of Insurance’s consumer toll-free telephone number*
24 *(1-800-927-HELP), by calling the Health Insurance Counseling*
25 *and Advocacy Program (HICAP) toll-free telephone number*
26 *(1-800-434-0222), or by accessing the Department of Insurance’s*
27 *Internet Web site (www.insurance.ca.gov).”*

28 ~~(5)~~

29 (6) Establish auditable procedures for verifying compliance
30 with this subdivision.

31 (b) In addition to the practices prohibited by this code or any
32 other law, the following acts and practices are prohibited:

33 (1) Twisting, which means knowingly making any misleading
34 representation or incomplete or fraudulent comparison of any
35 coverages or issuers for the purpose of inducing or tending to
36 induce, any person to lapse, forfeit, surrender, terminate, retain,
37 pledge, assign, borrow on, or convert any coverage or to take out
38 coverage with another plan or insurer.

39 (2) High pressure tactics, which means employing any method
40 of marketing having the effect of or tending to induce the purchase

1 of coverage through force, fright, threat, whether explicit or
2 implied, or undue pressure to purchase or recommend the purchase
3 of coverage.

4 (3) Cold lead advertising, which means making use directly or
5 indirectly of any method of marketing that fails to disclose in a
6 conspicuous manner that a purpose of the method of marketing is
7 the solicitation of coverage and that contact will be made by a
8 health care service plan or its representative.

9 (c) The terms “Medicare supplement,” “Medigap,” “Medicare
10 Wrap-Around” and words of similar import shall not be used unless
11 the contract is issued in compliance with this article.

12 *SEC. 13. Section 1358.24 is added to the Health and Safety*
13 *Code, to read:*

14 *1358.24. This section applies to all contracts that become*
15 *effective on or after May 21, 2009.*

16 *(a) In addition to the requirements set forth under Sections*
17 *1365.5 and 1374.7, an issuer of a Medicare supplement contract*
18 *shall adhere to the requirements imposed by the federal Genetic*
19 *Information Nondiscrimination Act of 2008 (Public Law 110-233)*
20 *as follows:*

21 *(1) The issuer shall not deny or condition the issuance or*
22 *effectiveness of the contract, including the imposition of any*
23 *exclusion of benefits under the contract based on a preexisting*
24 *condition, on the basis of the genetic information with respect to*
25 *that individual or a family member of the individual.*

26 *(2) The issuer shall not discriminate in the pricing of the*
27 *contract, including the adjustment of prepaid or periodic charges,*
28 *of an individual on the basis of the genetic information with respect*
29 *to that individual or a family member of the individual.*

30 *(b) Nothing in subdivision (a) shall be construed to limit the*
31 *ability of an issuer, to the extent otherwise permitted by law, to*
32 *do any of the following:*

33 *(1) Deny or condition the issuance or effectiveness of the*
34 *contract or increase the prepaid or periodic charge for a group*
35 *based on the manifestation of a disease or disorder of an enrollee,*
36 *subscriber, or applicant.*

37 *(2) Increase the prepaid or periodic charge for any contract*
38 *issued to an individual based on the manifestation of a disease or*
39 *disorder of an individual who is covered under the contract. For*
40 *purposes of this paragraph, the manifestation of a disease or*

1 *disorder in one individual shall not also be used as genetic*
2 *information about other group members and to further increase*
3 *the prepaid or periodic charge for the group.*

4 *(c) An issuer of a Medicare supplement contract shall not*
5 *request or require an individual or a family member of that*
6 *individual to undergo a genetic test.*

7 *(d) Subdivision (c) shall not be construed to preclude an issuer*
8 *of a Medicare supplement contract from obtaining and using the*
9 *results of a genetic test in making a determination regarding*
10 *payment, as defined for the purposes of applying the regulations*
11 *promulgated under Part C of Title XI and Section 264 of the Health*
12 *Insurance Portability and Accountability Act of 1996, as may be*
13 *revised from time to time, and consistent with subdivision (a).*

14 *(e) For purposes of carrying out subdivision (d), an issuer of a*
15 *Medicare supplement contract may request only the minimum*
16 *amount of information necessary to accomplish the intended*
17 *purpose.*

18 *(f) Notwithstanding subdivision (b) of Section 1374.7 or*
19 *subdivision (c), an issuer of a Medicare supplement contract may*
20 *request, but not require, that an individual or a family member of*
21 *that individual undergo a genetic test if each of the following*
22 *conditions is met:*

23 *(1) The request is made pursuant to research that complies with*
24 *Part 46 of Title 45 of the Code of Federal Regulations, or*
25 *equivalent federal regulations, and any applicable state or local*
26 *law or regulations for the protection of human subjects in research.*

27 *(2) The issuer clearly indicates both of the following to each*
28 *individual, or in the case of a minor child, to the legal guardian*
29 *of that child, to whom the request is made:*

30 *(A) Compliance with the request is voluntary.*

31 *(B) Noncompliance will have no effect on enrollment status,*
32 *prepaid or periodic charges, or contribution amounts.*

33 *(3) No genetic information collected or acquired under this*
34 *subdivision shall be used for any prohibited purpose described in*
35 *Section 1365.5 or subdivision (a) of Section 1374.7, as well as any*
36 *of the following: underwriting, determination of eligibility to enroll*
37 *or maintain enrollment status, determination of prepaid or periodic*
38 *charges, or the issuance, renewal, or replacement of a contract.*

39 *(4) The issuer notifies the United States Secretary of Health and*
40 *Human Services and the director in writing that the issuer is*

1 *conducting activities pursuant to the exception provided for under*
2 *this subdivision, including a description of the activities conducted.*

3 *(5) The issuer complies with any other conditions as the United*
4 *States Secretary of Health and Human Services may by regulation*
5 *require for activities conducted under this subdivision.*

6 *(g) An issuer of a Medicare supplement contract shall not*
7 *request, require, seek, or purchase genetic information for*
8 *underwriting purposes.*

9 *(h) An issuer of a Medicare supplement contract shall not*
10 *request, require, seek, or purchase genetic information with respect*
11 *to any individual or a family member of that individual prior to*
12 *the individual's enrollment under the contract in connection with*
13 *that enrollment.*

14 *(i) If an issuer of a Medicare supplement contract obtains*
15 *genetic information incidental to the requesting, requiring, or*
16 *purchasing of other information concerning any individual or a*
17 *family member of that individual, the request, requirement, or*
18 *purchase shall not be considered a violation of subdivision (h) if*
19 *the request, requirement, or purchase is not in violation of*
20 *subdivision (g). However, the issuer shall not use any genetic*
21 *information obtained under this section for any prohibited purpose*
22 *described in this section or in Sections 1365.5 and 1374.7.*

23 *(j) For the purposes of this section, the following definitions*
24 *shall apply:*

25 *(1) "Issuer of a Medicare supplement contract" includes a*
26 *third-party administrator, or other person acting for or on behalf*
27 *of an issuer.*

28 *(2) "Family member" means, with respect to an individual, any*
29 *other individual who is a first-degree, second-degree, third-degree,*
30 *or fourth-degree relative of the individual.*

31 *(3) "Genetic information" means, with respect to any individual,*
32 *information about the individual's genetic tests, the genetic tests*
33 *of family members of the individual, and the manifestation of a*
34 *disease or disorder in family members of the individual. The term*
35 *includes, with respect to any individual, any request for, or receipt*
36 *of, genetic services, or participation in clinical research which*
37 *includes genetic services, by the individual or any family member*
38 *of the individual. Any reference to genetic information concerning*
39 *an individual or family member of an individual who is a pregnant*
40 *woman, includes genetic information of any fetus carried by that*

1 *pregnant woman, or with respect to an individual or family member*
2 *utilizing reproductive technology, includes genetic information of*
3 *any embryo legally held by an individual or family member. The*
4 *term “genetic information” does not include information about*
5 *the sex or age of any individual.*

6 (4) *“Genetic services” means a genetic test, genetic education,*
7 *genetic counseling, including obtaining, interpreting, or assessing*
8 *genetic information.*

9 (5) *“Genetic test” means an analysis of human DNA, RNA,*
10 *chromosomes, proteins, or metabolites, that detect genotypes,*
11 *mutations, or chromosomal changes. The term “genetic test” does*
12 *not mean an analysis of proteins or metabolites that does not detect*
13 *genotypes, mutations, or chromosomal changes; or an analysis of*
14 *proteins or metabolites that is directly related to a manifested*
15 *disease, disorder, or pathological condition that could reasonably*
16 *be detected by a health care professional with appropriate training*
17 *and expertise in the field of medicine involved.*

18 (6) *“Underwriting purposes” includes all of the following:*

19 (A) *Rules for, or determination of, eligibility, including*
20 *enrollment and continued eligibility, for benefits under the contract.*

21 (B) *The computation of prepaid or periodic charges or*
22 *contribution amounts under the contract.*

23 (C) *The application of any preexisting condition exclusion under*
24 *the contract.*

25 (D) *Other activities related to the creation, renewal, or*
26 *replacement of a contract of health insurance or health benefits.*

27 **SECTION 1.**

28 **SEC. 14.** Section 785 of the Insurance Code is amended to
29 read:

30 785. (a) All insurers, brokers, agents, and others engaged in
31 the transaction of insurance owe a prospective insured who is 65
32 years of age or older, a duty of honesty, good faith, and fair dealing.
33 This duty is in addition to any other duty, whether express or
34 implied, that may exist.

35 (b) Conduct of an insurer, broker, or agent, or other person
36 engaged in the transaction of insurance, during the offer and sale
37 of a policy or certificate previous to the purchase is relevant to any
38 action alleging a breach of the duty of good faith and fair dealing.

39 (c) Except where explicitly provided to the contrary, this article
40 shall not apply to any of the following:

1 (1) Medicare supplement insurance as defined in subdivision
2 (m) of Section 10192.4.

3 (2) Long-term care insurance as defined in Section 10231.2.

4 (3) Disability coverage provided through the insured's employer
5 or former employer.

6 (4) Disability insurance policies or certificates principally
7 designed to provide coverage for accidents or expenses incurred
8 while traveling if the premium for the policy or certificate is ten
9 dollars (\$10) or less.

10 (5) Blanket disability insurance as defined in Section 10270.3.

11 (6) Credit disability insurance as defined in Section 779.2.

12 (7) Accidental death insurance.

13 (8) Until January 1, 2002, disability policies or certificates that
14 are sold through direct response methods of delivery.

15 (9) Disability income insurance as defined in subdivision (i) of
16 Section 799.01.

17 (d) Provided that the requirements of Section 10296 are met,
18 this article shall not apply to transportation ticket policies and
19 baggage insurance policy types allowable for sale by travel agents
20 pursuant to Section 1753.

21 ~~SEC. 2.~~

22 *SEC. 15.* Section 10192.4 of the Insurance Code is amended
23 to read:

24 10192.4. The following definitions apply for the purposes of
25 this article:

26 (a) "Applicant" means:

27 (1) The person who seeks to contract for insurance benefits, in
28 the case of an individual Medicare supplement policy.

29 (2) The proposed certificate holder, in the case of a group
30 Medicare supplement policy.

31 (b) "Bankruptcy" means that situation in which a Medicare
32 Advantage organization that is not an issuer has filed, or has had
33 filed against it, a petition for declaration of bankruptcy and has
34 ceased doing business in the state.

35 (c) "Certificate" means a certificate issued for delivery in this
36 state under a group Medicare supplement policy.

37 (d) "Certificate form" means the form on which the certificate
38 is issued for delivery by the issuer.

39 (e) "Continuous period of creditable coverage" means the period
40 during which an individual was covered by creditable coverage,

1 if during the period of the coverage the individual had no breaks
2 in coverage greater than 63 days.

3 (f) (1) “Creditable coverage” means, with respect to an
4 individual, coverage of the individual provided under any of the
5 following:

6 (A) Any individual or group contract, policy, certificate, or
7 program that is written or administered by a health care service
8 plan, health insurer, fraternal benefits society, self-insured
9 employer plan, or any other entity, in this state or elsewhere, and
10 that arranges or provides medical, hospital, and surgical coverage
11 not designed to supplement other private or governmental plans.
12 The term includes continuation or conversion coverage.

13 (B) Part A or B of Title XVIII of the federal Social Security
14 Act (Medicare).

15 (C) Title XIX of the federal Social Security Act (Medicaid
16 (known as Medi-Cal in California)), other than coverage consisting
17 solely of benefits under Section 1928 of that act.

18 (D) Chapter 55 of Title 10 of the United States Code
19 (CHAMPUS).

20 (E) A medical care program of the Indian Health Service or of
21 a tribal organization.

22 (F) A state health benefits risk pool.

23 (G) A health plan offered under Chapter 89 of Title 5 of the
24 United States Code (Federal Employees Health Benefits Program).

25 (H) A public health plan as defined in federal regulations
26 authorized by Section 2701(c)(1)(I) of the federal Public Health
27 Service Act, as amended by Public Law 104-191, the federal Health
28 Insurance Portability and Accountability Act of 1996.

29 (I) A health benefit plan under Section 5(e) of the federal Peace
30 Corps Act (Section 2504(e) of Title 22 of the United States Code).

31 (J) Any other publicly sponsored program, provided in this state
32 or elsewhere, of medical, hospital, and surgical care.

33 (K) Any other creditable coverage as defined by subsection (c)
34 of Section 2701 of Title XXVII of the federal Public Health
35 Services Act (42 U.S.C. Sec. 300gg(c)).

36 (2) “Creditable coverage” shall not include one or more, or any
37 combination of, the following:

38 (A) Coverage only for accident or disability income insurance,
39 or any combination thereof.

40 (B) Coverage issued as a supplement to liability insurance.

1 (C) Liability insurance, including general liability insurance
2 and automobile liability insurance.

3 (D) Workers' compensation or similar insurance.

4 (E) Automobile medical payment insurance.

5 (F) Credit-only insurance.

6 (G) Coverage for onsite medical clinics.

7 (H) Other similar insurance coverage, specified in federal
8 regulations, under which benefits for medical care are secondary
9 or incidental to other insurance benefits.

10 (3) "Creditable coverage" shall not include the following
11 benefits if they are provided under a separate policy, certificate,
12 or contract of insurance or are otherwise not an integral part of the
13 plan:

14 (A) Limited scope dental or vision benefits.

15 (B) Benefits for long-term care, nursing home care, home health
16 care, community-based care, or any combination thereof.

17 (C) Other similar, limited benefits as are specified in federal
18 regulations.

19 (4) "Creditable coverage" shall not include the following
20 benefits if offered as independent, noncoordinated benefits:

21 (A) Coverage only for a specified disease or illness.

22 (B) Hospital indemnity or other fixed indemnity insurance.

23 (5) "Creditable coverage" shall not include the following if
24 offered as a separate policy, certificate, or contract of insurance:

25 (A) Medicare supplemental health insurance as defined under
26 Section 1882(g)(1) of the federal Social Security Act.

27 (B) Coverage supplemental to the coverage provided under
28 Chapter 55 of Title 10 of the United States Code.

29 (C) Similar supplemental coverage provided to coverage under
30 a group health plan.

31 (g) "Employee welfare benefit plan" means a plan, fund, or
32 program of employee benefits as defined in Section 1002 of Title
33 29 of the United States Code (Employee Retirement Income
34 Security Act).

35 (h) "Insolvency" means when an issuer, licensed to transact the
36 business of insurance in this state, has had a final order of
37 liquidation entered against it with a finding of insolvency by a
38 court of competent jurisdiction in the issuer's state of domicile.

39 (i) "Issuer" includes insurance companies, fraternal benefit
40 societies, and any other entity delivering, or issuing for delivery,

1 Medicare supplement policies or certificates in this state, except
2 entities subject to Article 3.5 (commencing with Section 1358) of
3 Chapter 2.2 of Division 2 of the Health and Safety Code.

4 (j) “Medi-Cal” means California’s version of Medicaid under
5 Title XIX of the federal Social Security Act.

6 (k) “Medicare” means the Health Insurance for the Aged Act,
7 Title XVIII of the Social Security Amendments of 1965, as
8 amended.

9 (l) “Medicare Advantage plan” means a plan of coverage for
10 health benefits under Medicare Part C and includes:

11 (1) Coordinated care plans that provide health care services,
12 including, but not limited to, health care service plans (with or
13 without a point-of-service option), plans offered by
14 provider-sponsored organizations, and preferred provider
15 organizations plans.

16 (2) Medical savings account plans coupled with a contribution
17 into a Medicare Advantage medical savings account.

18 (3) Medicare Advantage private fee-for-service plans.

19 (m) “Medicare supplement policy” means a group or individual
20 policy of health insurance, other than a policy issued pursuant to
21 a contract under Section 1876 of the federal Social Security Act
22 (42 U.S.C. Section 1395mm) or an issued policy under a
23 demonstration project specified in Section 1395ss(g)(1) of Title
24 42 of the United States Code, that is advertised, marketed, or
25 designed primarily as a supplement to reimbursements under
26 Medicare for the hospital, medical, or surgical expenses of persons
27 eligible for Medicare. “Medicare supplement policy” does not
28 include a Medicare Advantage plan established under Medicare
29 Part C, an outpatient prescription drug plan established under
30 Medicare Part D, or a health care prepayment plan that provides
31 benefits pursuant to an agreement under subparagraph (A) of
32 paragraph (1) of subsection (a) of Section 1833 of the Social
33 Security Act.

34 (n) “Policy form” means the form on which the policy is issued
35 for delivery by the issuer.

36 (o) “Prestandardized Medicare supplement benefit plan,”
37 “prestandardized benefit plan,” or “prestandardized plan” means
38 a group or individual policy of Medicare supplement insurance
39 issued prior to July 21, 1992.

(p) “1990 standardized Medicare supplement benefit plan,” “1990 standardized benefit plan,” or “1990 plan” means a group or individual policy of Medicare supplement insurance issued on or after July 21, 1992, and *with an effective date* prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

(q) “2010 standardized Medicare supplement benefit plan,” “2010 standardized benefit plan,” or “2010 plan” means a group or individual policy of Medicare supplement insurance issued *with an effective date* on or after June 1, 2010.

(r) “Secretary” means the Secretary of the United States Department of Health and Human Services.

~~SEC. 3.~~

SEC. 16. Section 10192.6 of the Insurance Code is amended to read:

10192.6. (a) Except for permitted preexisting condition clauses as described in Sections 10192.7, 10192.8, and 10192.81, a policy or certificate shall not be advertised, solicited, or issued for delivery as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(b) A Medicare supplement policy or certificate shall not use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(c) A Medicare supplement policy or certificate in force shall not contain benefits that duplicate benefits provided by Medicare.

(d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of Section 10192.8, a Medicare supplement policy with benefits for outpatient prescription drugs that was issued prior to January 1, 2006, shall be renewed for current policyholders, at the option of the policyholder, who do not enroll in Medicare Part D.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued on and after January 1, 2006.

(3) On and after January 1, 2006, a Medicare supplement policy with benefits for outpatient prescription drugs shall not be renewed after the policyholder enrolls in Medicare Part D unless both of the following conditions exist:

1 (A) The policy is modified to eliminate outpatient prescription
2 drug coverage for outpatient prescription drug expenses incurred
3 after the effective date of the individual's coverage under a
4 Medicare Part D plan.

5 (B) The premium is adjusted to reflect the elimination of
6 outpatient prescription drug coverage at the time of enrollment in
7 Medicare Part D, accounting for any claims paid if applicable.

8 ~~SEC. 4.~~

9 *SEC. 17.* Section 10192.8 of the Insurance Code is amended
10 to read:

11 10192.8. The following standards are applicable to all Medicare
12 supplement policies or certificates advertised, solicited, or issued
13 for delivery on or after January 1, 2001, and *with an effective date*
14 prior to June 1, 2010. A policy or certificate shall not be advertised,
15 solicited, or issued for delivery as a Medicare supplement policy
16 or certificate unless it complies with these benefit standards.

17 (a) The following general standards apply to Medicare
18 supplement policies and certificates and are in addition to all other
19 requirements of this article:

20 (1) A Medicare supplement policy or certificate shall not exclude
21 or limit benefits for losses incurred more than six months from the
22 effective date of coverage because it involved a preexisting
23 condition. The policy or certificate shall not define a preexisting
24 condition more restrictively than a condition for which medical
25 advice was given or treatment was recommended by or received
26 from a physician within six months before the effective date of
27 coverage.

28 (2) A Medicare supplement policy or certificate shall not
29 indemnify against losses resulting from sickness on a different
30 basis than losses resulting from accidents.

31 (3) A Medicare supplement policy or certificate shall provide
32 that benefits designed to cover cost-sharing amounts under
33 Medicare will be changed automatically to coincide with any
34 changes in the applicable Medicare deductible, copayment, or
35 coinsurance amounts. Premiums may be modified to correspond
36 with those changes.

37 (4) A Medicare supplement policy or certificate shall not provide
38 for termination of coverage of a spouse solely because of the
39 occurrence of an event specified for termination of coverage of
40 the insured, other than the nonpayment of premium.

1 (5) Each Medicare supplement policy shall be guaranteed
2 renewable or noncancelable.

3 (A) The issuer shall not cancel or nonrenew the policy solely
4 on the ground of health status of the individual.

5 (B) The issuer shall not cancel or nonrenew the policy for any
6 reason other than nonpayment of premium or misrepresentation
7 which is shown by the issuer to be material to the acceptance for
8 coverage. The contestability period for Medicare supplement
9 insurance shall be two years.

10 (C) If the Medicare supplement policy is terminated by the
11 master policyholder and is not replaced as provided under
12 subparagraph (E), the issuer shall offer certificate holders an
13 individual Medicare supplement policy that, at the option of the
14 certificate holder, either provides for continuation of the benefits
15 contained in the group policy or provides for benefits that otherwise
16 meet the requirements of one of the standardized policies defined
17 in this article.

18 (D) If an individual is a certificate holder in a group Medicare
19 supplement policy and membership in the group is terminated, the
20 issuer shall either offer the certificate holder the conversion
21 opportunity described in subparagraph (C) or, at the option of the
22 group policyholder, shall offer the certificate holder continuation
23 of coverage under the group policy.

24 (E) (i) If a group Medicare supplement policy is replaced by
25 another group Medicare supplement policy purchased by the same
26 policyholder, the issuer of the replacement policy shall offer
27 coverage to all persons covered under the old group policy on its
28 date of termination. Coverage under the new policy shall not result
29 in any exclusion for preexisting conditions that would have been
30 covered under the group policy being replaced.

31 (ii) If a Medicare supplement policy or certificate replaces
32 another Medicare supplement policy or certificate that has been
33 in force for six months or more, the replacing issuer shall not
34 impose an exclusion or limitation based on a preexisting condition.
35 If the original coverage has been in force for less than six months,
36 the replacing issuer shall waive any time period applicable to
37 preexisting conditions, waiting periods, elimination periods, or
38 probationary periods in the new policy or certificate to the extent
39 the time was spent under the original coverage.

1 (F) If a Medicare supplement policy eliminates an outpatient
2 prescription drug benefit as a result of requirements imposed by
3 the Medicare Prescription Drug, Improvement, and Modernization
4 Act of 2003 (P.L. 108-173), the policy as modified as a result of
5 that act shall be deemed to satisfy the guaranteed renewal
6 requirements of this paragraph.

7 (6) Termination of a Medicare supplement policy or certificate
8 shall be without prejudice to any continuous loss that commenced
9 while the policy was in force, but the extension of benefits beyond
10 the period during which the policy was in force may be predicated
11 upon the continuous total disability of the insured, limited to the
12 duration of the policy benefit period, if any, or to payment of the
13 maximum benefits. Receipt of Medicare Part D benefits shall not
14 be considered in determining a continuous loss.

15 (7) (A) (i) A Medicare supplement policy or certificate shall
16 provide that benefits and premiums under the policy or certificate
17 shall be suspended at the request of the policyholder or certificate
18 holder for the period, not to exceed 24 months, in which the
19 policyholder or certificate holder has applied for and is determined
20 to be entitled to Medi-Cal, but only if the policyholder or certificate
21 holder notifies the issuer of the policy or certificate within 90 days
22 after the date the individual becomes entitled to assistance. Upon
23 receipt of timely notice, the insurer shall return directly to the
24 insured that portion of the premium attributable to the period of
25 Medi-Cal eligibility, subject to adjustment for paid claims. If
26 suspension occurs and if the policyholder or certificate holder loses
27 entitlement to Medi-Cal, the policy or certificate shall be
28 automatically reinstituted, effective as of the date of termination
29 of entitlement, as of the termination of entitlement if the
30 policyholder or certificate holder provides notice of loss of
31 entitlement within 90 days after the date of loss and pays the
32 premium attributable to the period, effective as of the date of
33 termination of entitlement, or equivalent coverage shall be provided
34 if the prior form is no longer available.

35 (ii) A Medicare supplement policy or certificate shall provide
36 that benefits and premiums under the policy or certificate shall be
37 suspended at the request of the policyholder or certificate holder
38 for any period that may be provided by federal regulation if the
39 policyholder is entitled to benefits under Section 226(b) of the
40 Social Security Act and is covered under a group health plan, as

1 defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If
2 suspension occurs and the policyholder or certificate holder loses
3 coverage under the group health plan, the policy or certificate shall
4 be automatically reinstituted, effective as of the date of loss of
5 coverage if the policyholder provides notice within 90 days of the
6 date of the loss of coverage.

7 (B) Reinstitution of coverages:

8 (i) Shall not provide for any waiting period with respect to
9 treatment of preexisting conditions.

10 (ii) Shall provide for resumption of coverage that is substantially
11 equivalent to coverage in effect before the date of suspension. If
12 the suspended Medicare supplement policy provided coverage for
13 outpatient prescription drugs, reinstitution of the policy for a
14 Medicare Part D enrollee shall not include coverage for outpatient
15 prescription drugs but shall otherwise provide coverage that is
16 substantially equivalent to the coverage in effect before the date
17 of suspension.

18 (iii) Shall provide for classification of premiums on terms at
19 least as favorable to the policyholder or certificate holder as the
20 premium classification terms that would have applied to the
21 policyholder or certificate holder had the coverage not been
22 suspended.

23 (8) If an issuer makes a written offer to the Medicare supplement
24 policyholders or certificate holders of one or more of its plans, to
25 exchange during a specified period from his or her 1990
26 standardized plan, as described in Section 10192.9, to a 2010
27 standardized plan, as described in Section 10192.91, the offer and
28 subsequent exchange shall comply with the following requirements:

29 (A) An issuer need not provide justification to the commissioner
30 if the insured replaces a 1990 standardized policy or certificate
31 with an issue age rated 2010 standardized policy or certificate at
32 the insured's original issue age and duration. If an insured's policy
33 or certificate to be replaced is priced on an issue age rate schedule
34 at the time of that offer, the rate charged to the insured for the new
35 exchanged policy shall recognize the policy reserve buildup, due
36 to the prefunding inherent in the use of an issue age rate basis, for
37 the benefit of the insured. The method proposed to be used by an
38 issuer ~~must~~ *shall* be filed with the commissioner.

39 (B) The rating class of the new policy or certificate shall be the
40 class closest to the insured's class of the replaced coverage.

1 (C) An issuer shall not apply new preexisting condition
2 limitations or a new incontestability period to the new policy for
3 those benefits contained in the exchanged 1990 standardized policy
4 or certificate of the insured, but may apply preexisting condition
5 limitations of no more than six months to any added benefits
6 contained in the new 2010 standardized policy or certificate not
7 contained in the exchanged policy. This subdivision shall not apply
8 to an applicant who is guaranteed issue under Section 10192.11
9 or 10192.12.

10 (D) The new policy or certificate shall be offered to all
11 policyholders or certificate holders within a given plan, except
12 where the offer or issue would be in violation of state or federal
13 law.

14 (9) A Medicare supplement policy ~~shall cover the applicable~~
15 ~~coinsurance and deductible for any illness or disease covered by~~
16 ~~Medicare, plus expenses for any illness or disease covered by the~~
17 ~~individual's applicable Medicare supplement plan. may limit~~
18 *coverage exclusively to a single disease or affliction.*

19 (b) With respect to the standards for basic (core) benefits for
20 benefit plans A to J, inclusive, every issuer shall make available
21 a policy or certificate including only the following basic "core"
22 package of benefits to each prospective insured. An issuer may
23 make available to prospective insureds any of the other Medicare
24 supplement insurance benefit plans in addition to the basic core
25 package, but not in lieu of it. *However, the benefits described in*
26 *paragraphs (6) and (7) shall not be offered so long as California*
27 *is required to disallow these benefits for Medicare beneficiaries*
28 *by the Centers for Medicare and Medicaid Services or other agent*
29 *of the federal government under Section 1395ss of Title 42 of the*
30 *United States Code.*

31 (1) Coverage of Part A Medicare eligible expenses for
32 hospitalization to the extent not covered by Medicare from the
33 61st day to the 90th day, inclusive, in any Medicare benefit period.

34 (2) Coverage of Part A Medicare eligible expenses incurred for
35 hospitalization to the extent not covered by Medicare for each
36 Medicare lifetime inpatient reserve day used.

37 (3) Upon exhaustion of the Medicare hospital inpatient coverage
38 including the lifetime reserve days, coverage of 100 percent of the
39 Medicare Part A eligible expenses for hospitalization paid at the
40 appropriate Medicare standard of payment, subject to a lifetime

1 maximum benefit of an additional 365 days. The provider shall
2 accept the issuer's payment as payment in full and may not bill
3 the insured for any balance.

4 (4) Coverage under Medicare Parts A and B for the reasonable
5 cost of the first three pints of blood, or equivalent quantities of
6 packed red blood cells, as defined under federal regulations, unless
7 replaced in accordance with federal regulations.

8 (5) Coverage for the coinsurance amount, or in the case of
9 hospital outpatient department services, the copayment amount,
10 of Medicare eligible expenses under Part B regardless of hospital
11 confinement, subject to the Medicare Part B deductible.

12 (6) Coverage of the actual cost, up to the legally billed amount,
13 of an annual mammogram as provided in Section 10123.81, to the
14 extent not paid by Medicare.

15 (7) Coverage of the actual cost, up to the legally billed amount,
16 of an annual cervical cancer screening test as provided in Section
17 10123.18, to the extent not paid by Medicare.

18 (c) The following additional benefits shall be included in
19 Medicare supplement benefit plans B to J, inclusive, only as
20 provided by Section 10192.9.

21 (1) With respect to the Medicare Part A deductible, coverage
22 for all of the Medicare Part A inpatient hospital deductible amount
23 per benefit period.

24 (2) With respect to skilled nursing facility care, coverage for
25 the actual billed charges up to the coinsurance amount from the
26 21st day to the 100th day, inclusive, in a Medicare benefit period
27 for posthospital skilled nursing facility care eligible under Medicare
28 Part A.

29 (3) With respect to the Medicare Part B deductible, coverage
30 for all of the Medicare Part B deductible amount per calendar year
31 regardless of hospital confinement.

32 (4) With respect to 80 percent of the Medicare Part B excess
33 charges, coverage for 80 percent of the difference between the
34 actual Medicare Part B charge as billed, not to exceed any charge
35 limitation established by the Medicare Program or state law, and
36 the Medicare-approved Part B charge. If the insurer limits payment
37 to a limiting charge, the insurer has the burden to establish that
38 amount as the legal limit.

39 (5) With respect to 100 percent of the Medicare Part B excess
40 charges, coverage for all of the difference between the actual

1 Medicare Part B charge as billed, not to exceed any charge
2 limitation established by the Medicare Program or state law, and
3 the Medicare-approved Part B charge. If the insurer limits payment
4 to a limiting charge, the insurer has the burden to establish that
5 amount as the legal limit.

6 (6) With respect to the basic outpatient prescription drug benefit,
7 coverage for 50 percent of outpatient prescription drug charges,
8 after a two hundred fifty dollar (\$250) calendar year deductible,
9 to a maximum of one thousand two hundred fifty dollars (\$1,250)
10 in benefits received by the insured per calendar year, to the extent
11 not covered by Medicare. On and after January 1, 2006, no
12 Medicare supplement policy may be sold or issued if it includes
13 a prescription drug benefit.

14 (7) With respect to the extended outpatient prescription drug
15 benefit, coverage for 50 percent of outpatient prescription drug
16 charges, after a two hundred fifty dollar (\$250) calendar year
17 deductible, to a maximum of three thousand dollars (\$3,000) in
18 benefits received by the insured per calendar year, to the extent
19 not covered by Medicare. On and after January 1, 2006, no
20 Medicare supplement policy may be sold or issued if it includes
21 a prescription drug benefit.

22 (8) With respect to medically necessary emergency care in a
23 foreign country, coverage to the extent not covered by Medicare
24 for 80 percent of the billed charges for Medicare-eligible expenses
25 for medically necessary emergency hospital, physician, and medical
26 care received in a foreign country, which care would have been
27 covered by Medicare if provided in the United States and which
28 care began during the first 60 consecutive days of each trip outside
29 the United States, subject to a calendar year deductible of two
30 hundred fifty dollars (\$250), and a lifetime maximum benefit of
31 fifty thousand dollars (\$50,000). For purposes of this benefit,
32 “emergency care” shall mean care needed immediately because
33 of an injury or an illness of sudden and unexpected onset.

34 (9) With respect to the following, reimbursement shall be for
35 the actual charges up to 100 percent of the Medicare-approved
36 amount for each service, as if Medicare were to cover the service
37 as identified in American Medical Association Current Procedural
38 Terminology (AMA CPT) codes, up to a maximum of one hundred
39 twenty dollars (\$120) annually under this benefit, however, this

benefit shall not include payment for any procedure covered by Medicare:

(A) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (B) and patient education to address preventive health care measures.

(B) The following screening tests or preventive services that are not covered by Medicare, the selection and frequency of which are determined to be medically appropriate by the attending physician:

(i) Fecal occult blood test.

(ii) Mammogram.

(C) Influenza vaccine administered at any appropriate time during the year.

(10) With respect to the at-home recovery benefit, coverage for the actual charges up to forty dollars (\$40) per visit and an annual maximum of one thousand six hundred dollars (\$1,600) per year to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(A) For purposes of this benefit, the following definitions shall apply:

(i) “Activities of daily living” include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) “Care provider” means a duly qualified or licensed home health aide or homemaker, or a personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) “Home” shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured’s place of residence.

(iv) “At-home recovery visit” means the period of a visit required to provide at-home recovery care, without any limit on the duration of the visit, except that each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

(B) With respect to coverage requirements and limitations, the following shall apply:

(i) At-home recovery services provided shall be primarily services that assist in activities of daily living.

(ii) The insured's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to the following:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit.

(III) One thousand six hundred dollars (\$1,600) per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in subparagraph (A).

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.

(C) Coverage is excluded for the following:

(i) Home care visits paid for by Medicare or other government programs.

(ii) Care provided by family members, unpaid volunteers, or providers who are not care providers.

(d) The standardized Medicare supplement benefit plan "K" shall consist of the following benefits:

(1) Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each day used from the 61st to the 90th day, inclusive, in any Medicare benefit period.

(2) Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve

1 day used from the 91st to the 150th day, inclusive, in any Medicare
2 benefit period.

3 (3) Upon exhaustion of the Medicare hospital inpatient
4 coverage, including the lifetime reserve days, coverage of 100
5 percent of the Medicare Part A eligible expenses for hospitalization
6 paid at the applicable prospective payment system rate, or other
7 appropriate Medicare standard of payment, subject to a lifetime
8 maximum benefit of an additional 365 days. The provider shall
9 accept the issuer's payment for this benefit as payment in full and
10 shall not bill the insured for any balance.

11 (4) With respect to the Medicare Part A deductible, coverage
12 for 50 percent of the Medicare Part A inpatient hospital deductible
13 amount per benefit period until the out-of-pocket limitation
14 described in paragraph (10) is met.

15 (5) With respect to skilled nursing facility care, coverage for
16 50 percent of the coinsurance amount for each day used from the
17 21st day to the 100th day, inclusive, in a Medicare benefit period
18 for posthospital skilled nursing facility care eligible under Medicare
19 Part A until the out-of-pocket limitation described in paragraph
20 (10) is met.

21 (6) With respect to hospice care, coverage for 50 percent of cost
22 sharing for all Medicare Part A eligible expenses and respite care
23 until the out-of-pocket limitation described in paragraph (10) is
24 met.

25 (7) Coverage for 50 percent, under Medicare Part A or B, of
26 the reasonable cost of the first three pints of blood or equivalent
27 quantities of packed red blood cells, as defined under federal
28 regulations, unless replaced in accordance with federal regulations,
29 until the out-of-pocket limitation described in paragraph (10) is
30 met.

31 (8) Except for coverage provided in paragraph (9), coverage for
32 50 percent of the cost sharing otherwise applicable under Medicare
33 Part B after the policyholder pays the Part B deductible, until the
34 out-of-pocket limitation is met as described in paragraph (10).

35 (9) Coverage of 100 percent of the cost sharing for Medicare
36 Part B preventive services, after the policyholder pays the Medicare
37 Part B deductible.

38 (10) Coverage of 100 percent of all cost sharing under Medicare
39 Parts A and B for the balance of the calendar year after the
40 individual has reached the out-of-pocket limitation on annual

1 expenditures under Medicare Parts A and B of four thousand
2 dollars (\$4,000) in 2006, indexed each year by the appropriate
3 inflation adjustment specified by the secretary.

4 (e) The standardized Medicare supplement benefit plan “L”
5 shall consist of the following benefits:

6 (1) The benefits described in paragraphs (1), (2), (3), and (9) of
7 subdivision (d).

8 (2) With respect to the Medicare Part A deductible, coverage
9 for 75 percent of the Medicare Part A inpatient hospital deductible
10 amount per benefit period until the out-of-pocket limitation
11 described in paragraph (8) is met.

12 (3) With respect to skilled nursing facility care, coverage for
13 75 percent of the coinsurance amount for each day used from the
14 21st day to the 100th day, inclusive, in a Medicare benefit period
15 for posthospital skilled nursing facility care eligible under Medicare
16 Part A until the out-of-pocket limitation described in paragraph
17 (8) is met.

18 (4) With respect to hospice care, coverage for 75 percent of cost
19 sharing for all Medicare Part A eligible expenses and respite care
20 until the out-of-pocket limitation described in paragraph (8) is met.

21 (5) Coverage for 75 percent, under Medicare Part A or B, of
22 the reasonable cost of the first three pints of blood or equivalent
23 quantities of packed red blood cells, as defined under federal
24 regulations, unless replaced in accordance with federal regulations,
25 until the out-of-pocket limitation described in paragraph (8) is met.

26 (6) Except for coverage provided in paragraph (7), coverage for
27 75 percent of the cost sharing otherwise applicable under Medicare
28 Part B after the policyholder pays the Part B deductible until the
29 out-of-pocket limitation described in paragraph (8) is met.

30 (7) Coverage for 100 percent of the cost sharing for Medicare
31 Part B preventive services after the policyholder pays the Part B
32 deductible.

33 (8) Coverage of 100 percent of the cost sharing for Medicare
34 Parts A and B for the balance of the calendar year after the
35 individual has reached the out-of-pocket limitation on annual
36 expenditures under Medicare Parts A and B of two thousand dollars
37 (\$2,000) in 2006, indexed each year by the appropriate inflation
38 adjustment specified by the secretary.

39 (f) An issuer shall prominently indicate through text edits, or
40 by other means acceptable to the commissioner, an amendment

1 made to a Medicare supplement policy form that the department
2 previously approved on the basis that the amendment is consistent
3 with this section. The department may, in its discretion, restrict its
4 review to amendments made to Medicare supplement policy forms
5 that have not previously been found consistent with this section
6 in order to facilitate the availability of amended policy forms that
7 are consistent with the federal Medicare Modernization Act. The
8 department shall not restrict its review if the amendment makes
9 additional changes to the Medicare supplement policy form.

10 ~~SEC. 5.~~

11 *SEC. 18.* Section 10192.81 is added to the Insurance Code, to
12 read:

13 10192.81. The following standards are applicable to all
14 Medicare supplement policies or certificates delivered or issued
15 for delivery in this state *with an effective date* on or after June 1,
16 2010. No policy or certificate may be advertised, solicited,
17 delivered, or issued for delivery in this state as a Medicare
18 supplement policy or certificate unless it complies with these
19 benefit standards. No issuer may offer any 1990 standardized
20 Medicare supplement benefit plan for sale *with an effective date*
21 on or after June 1, 2010. Benefit standards applicable to Medicare
22 supplement policies and certificates issued ~~before~~ *with an effective*
23 *date prior to* June 1, 2010, remain subject to the requirements of
24 Section 10192.8.

25 (a) The following general standards apply to Medicare
26 supplement policies and certificates and are in addition to all other
27 requirements of this article.

28 (1) A Medicare supplement policy or certificate shall not exclude
29 or limit benefits for losses incurred more than six months from the
30 effective date of coverage because it involved a preexisting
31 condition. The policy or certificate shall not define a preexisting
32 condition more restrictively than a condition for which medical
33 advice was given or treatment was recommended by or received
34 from a physician within six months before the effective date of
35 coverage.

36 (2) A Medicare supplement policy or certificate shall not
37 indemnify against losses resulting from sickness on a different
38 basis than losses resulting from accidents.

39 (3) A Medicare supplement policy or certificate shall provide
40 that benefits designed to cover cost-sharing amounts under

1 Medicare will be changed automatically to coincide with any
2 changes in the applicable Medicare deductible, copayment, or
3 coinsurance amounts. Premiums may be modified to correspond
4 with ~~such~~ *those* changes.

5 (4) A Medicare supplement policy or certificate shall not provide
6 for termination of coverage of a spouse solely because of the
7 occurrence of an event specified for termination of coverage of
8 the insured, other than the nonpayment of premium.

9 (5) Each Medicare supplement policy shall be guaranteed
10 renewable.

11 (A) The issuer shall not cancel or nonrenew the policy solely
12 on the ground of health status of the individual.

13 (B) The issuer shall not cancel or nonrenew the policy for any
14 reason other than nonpayment of premium or material
15 misrepresentation which is shown by the issuer to be material to
16 the acceptance for coverage. The contestability period for Medicare
17 supplement insurance shall be two years, *pursuant to Section*
18 *10305.2*.

19 (C) If the Medicare supplement policy is terminated by the
20 master policyholder and is not replaced as provided under
21 subparagraph (E), the issuer shall offer certificate holders an
22 individual Medicare supplement policy which, at the option of the
23 certificate holder, does one of the following:

24 (i) Provides for continuation of the benefits contained in the
25 group policy.

26 (ii) Provides for benefits that otherwise meet the requirements
27 of one of the standardized policies defined in this article.

28 (D) If an individual is a certificate holder in a group Medicare
29 supplement policy and the individual terminates membership in
30 the group, the issuer shall do one of the following:

31 (i) Offer the certificate holder the conversion opportunity
32 described in subparagraph (C).

33 (ii) At the option of the group policyholder, offer the certificate
34 holder continuation of coverage under the group policy.

35 (E) (i) If a group Medicare supplement policy is replaced by
36 another group Medicare supplement policy purchased by the same
37 policyholder, the issuer of the replacement policy shall offer
38 coverage to all persons covered under the old group policy on its
39 date of termination. Coverage under the new policy shall not result

1 in any exclusion for preexisting conditions that would have been
2 covered under the group policy being replaced.

3 (ii) If a Medicare supplement policy or certificate replaces
4 another Medicare supplement policy or certificate that has been
5 in force for six months or more, the replacing issuer shall not
6 impose an exclusion or limitation based on a preexisting condition.

7 If the original coverage has been in force for less than six months,
8 the replacing issuer shall waive any time period applicable to
9 preexisting conditions, waiting periods, elimination periods, or
10 probationary periods in the new policy or certificate to the extent
11 the time was spent under the original coverage.

12 (6) Termination of a Medicare supplement policy or certificate
13 shall be without prejudice to any continuous loss that commenced
14 while the policy was in force, but the extension of benefits beyond
15 the period during which the policy was in force may be predicated
16 upon the continuous total disability of the insured, limited to the
17 duration of the policy benefit period, if any, or payment of the
18 maximum benefits. Receipt of Medicare Part D benefits ~~will~~ *shall*
19 not be considered in determining a continuous loss.

20 (7) (A) (i) A Medicare supplement policy or certificate shall
21 provide that benefits and premiums under the policy or certificate
22 shall be suspended at the request of the policyholder or certificate
23 holder for the period, not to exceed 24 months, in which the
24 policyholder or certificate holder has applied for and is determined
25 to be entitled to medical assistance under Medi-Cal, but only if
26 the policyholder or certificate holder notifies the issuer of the
27 policy or certificate within 90 days after the date the individual
28 becomes entitled to assistance. Upon receipt of timely notice, the
29 insurer shall return directly to the insured that portion of the
30 premium attributable to the period of Medi-Cal eligibility, subject
31 to adjustment for paid claims.

32 (ii) If suspension occurs and if the policyholder or certificate
33 holder loses entitlement to medical assistance under Medi-Cal, the
34 policy or certificate shall be automatically reinstituted, effective
35 as of the date of termination of entitlement, as of the termination
36 of entitlement if the policyholder or certificate holder provides
37 notice of loss of entitlement within 90 days after the date of loss
38 and pays the premium attributable to the period, effective as of the
39 date of termination of entitlement or equivalent coverage shall be
40 provided if the prior form is no longer available.

(iii) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the applicable premium.

(B) Reinstitution of coverages shall comply with all of the following requirements:

(i) Not provide for any waiting period with respect to treatment of preexisting conditions.

(ii) Provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension.

(iii) Provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

~~(8) A Medicare supplement policy shall cover the applicable coinsurance and deductible for any illness or disease covered by Medicare, plus expenses for any illness or disease covered by the individual's applicable Medicare supplement plan.~~

~~(b) Every~~ *With respect to the standards for basic (core) benefits for benefit plans A, B, C, D, F, F with high deductible, G, M, and N, every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic (core) package, but not in lieu of it. However, the benefits described in paragraphs (6) and (7) shall not be offered so long as California is required to disallow these benefits for Medicare beneficiaries by the centers for Medicare and Medicaid Services or other agent of the federal government under Section 1395ss of Title 42 of the United States Code.*

1 (1) Coverage of Part A Medicare eligible expenses for
2 hospitalization to the extent not covered by Medicare from the
3 61st day through the 90th day, inclusive, in any Medicare benefit
4 period.

5 (2) Coverage of Part A Medicare eligible expenses incurred for
6 hospitalization to the extent not covered by Medicare for each
7 Medicare lifetime inpatient reserve day used.

8 (3) Upon exhaustion of the Medicare hospital inpatient coverage,
9 including the lifetime reserve days, coverage of 100 percent of the
10 Medicare Part A eligible expenses for hospitalization paid at the
11 applicable prospective payment system (PPS) rate, or other
12 appropriate Medicare standard of payment, subject to a lifetime
13 maximum benefit of an additional 365 days. The provider shall
14 accept the issuer's payment as payment in full and may not bill
15 the insured for any balance.

16 (4) Coverage under Medicare Parts A and B for the reasonable
17 cost of the first three pints of ~~blood~~ *(or blood, or equivalent*
18 *quantities of packed red blood cells, as defined under federal*
19 *regulations)* *regulations*, unless replaced in accordance with federal
20 regulations.

21 (5) Coverage for the coinsurance amount, or in the case of
22 hospital outpatient department services paid under a prospective
23 payment system, the copayment amount, of Medicare eligible
24 expenses under Part B regardless of hospital confinement, subject
25 to the Medicare Part B deductible.

26 (6) Coverage of cost sharing for all Part A Medicare eligible
27 hospice care and respite care expenses.

28 (7) Coverage of the actual cost, up to the legally billed amount,
29 of an annual mammogram as provided in Section 10123.81, to the
30 extent not paid by Medicare.

31 (8) Coverage of the actual cost, up to the legally billed amount,
32 of an annual cervical cancer screening test as provided in Section
33 10123.18, to the extent not paid by Medicare.

34 (c) The following additional benefits shall be included in
35 Medicare supplement benefit ~~Plans~~ *plans* B, C, D, F, F with high
36 deductible, G, M, and N, as provided in Section 10192.91:

37 (1) With respect to the Medicare Part A deductible, coverage
38 for 100 percent of the Medicare Part A inpatient hospital deductible
39 amount per benefit period.

(2) With respect to the Medicare Part A deductible, coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

(3) With respect to skilled nursing facility care, coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for ~~post-hospital~~ *posthospital* skilled nursing facility care eligible under Medicare Part A.

(4) With respect to the Medicare Part B deductible, coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(5) With respect to *100 percent of the* Medicare Part B excess charges, coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) With respect to medically necessary emergency care in a foreign country, coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

~~SEC. 6.~~

SEC. 19. Section 10192.9 of the Insurance Code is amended to read:

10192.9. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state *on or after July 1, 1992, and with an effective date* prior to June 1, 2010.

(a) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subdivision (b) of Section 10192.8.

(b) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be

1 offered for sale in this state, except as may be permitted by
2 subdivision (f) and by Section 10192.10.

3 (c) Benefit plans shall be uniform in structure, language,
4 designation and format to the standard benefit plans A to J,
5 inclusive, listed in subdivision (e), and shall conform to the
6 definitions in Section 10192.4. Each benefit shall be structured in
7 accordance with the format provided in subdivisions (b), (c), (d),
8 and (e) of Section 10192.8 and list the benefits in the order listed
9 in subdivision (e). For purposes of this section, “structure,
10 language, and format” means style, arrangement, and overall
11 content of a benefit.

12 (d) An issuer may use, in addition to the benefit plan
13 designations required in subdivision (c), other designations to the
14 extent permitted by law.

15 (e) With respect to the makeup of benefit plans, the following
16 shall apply:

17 (1) Standardized Medicare supplement benefit plan A shall be
18 limited to the basic (core) benefit common to all benefit plans, as
19 defined in subdivision (b) of Section 10192.8.

20 (2) Standardized Medicare supplement benefit plan B shall
21 include only the following: the core benefit, plus the Medicare
22 Part A deductible as defined in paragraph (1) of subdivision (c) of
23 Section 10192.8.

24 (3) Standardized Medicare supplement benefit plan C shall
25 include only the following: the core benefit, plus the Medicare
26 Part A deductible, skilled nursing facility care, Medicare Part B
27 deductible, and medically necessary emergency care in a foreign
28 country as defined in paragraphs (1), (2), (3), and (8) of subdivision
29 (c) of Section 10192.8, respectively.

30 (4) Standardized Medicare supplement benefit plan D shall
31 include only the following: the core benefit, plus the Medicare
32 Part A deductible, skilled nursing facility care, medically necessary
33 emergency care in a foreign country, and the at-home recovery
34 benefit as defined in paragraphs (1), (2), (8), and (10) of
35 subdivision (c) of Section 10192.8, respectively.

36 (5) Standardized Medicare supplement benefit plan E shall
37 include only the following: the core benefit, plus the Medicare
38 Part A deductible, skilled nursing facility care, medically necessary
39 emergency care in a foreign country, and preventive medical care

1 as defined in paragraphs (1), (2), (8), and (9) of subdivision (c) of
2 Section 10192.8, respectively.

3 (6) Standardized Medicare supplement benefit plan F shall
4 include only the following: the core benefit, plus the Medicare
5 Part A deductible, the skilled nursing facility care, the Medicare
6 Part B deductible, 100 percent of the Medicare Part B excess
7 charges, and medically necessary emergency care in a foreign
8 country as defined in paragraphs (1), (2), (3), (5), and (8) of
9 subdivision (c) of Section 10192.8, respectively.

10 (7) Standardized Medicare supplement benefit high deductible
11 plan F shall include only the following: 100 percent of covered
12 expenses following the payment of the annual high deductible plan
13 F deductible. The covered expenses include the core benefit, plus
14 the Medicare Part A deductible, skilled nursing facility care, the
15 Medicare Part B deductible, 100 percent of the Medicare Part B
16 excess charges, and medically necessary emergency care in a
17 foreign country as defined in paragraphs (1), (2), (3), (5), and (8)
18 of subdivision (c) of Section 10192.8, respectively. The annual
19 high deductible plan F deductible shall consist of out-of-pocket
20 expenses, other than premiums, for services covered by the
21 Medicare supplement plan F policy, and shall be in addition to any
22 other specific benefit deductibles. The annual high deductible Plan
23 F deductible shall be one thousand five hundred dollars (\$1,500)
24 for 1998 and 1999, and shall be based on the calendar year, as
25 adjusted annually thereafter by the secretary to reflect the change
26 in the Consumer Price Index for all urban consumers for the
27 12-month period ending with August of the preceding year, and
28 rounded to the nearest multiple of ten dollars (\$10).

29 (8) Standardized Medicare supplement benefit plan G shall
30 include only the following: the core benefit, plus the Medicare
31 Part A deductible, skilled nursing facility care, 80 percent of the
32 Medicare Part B excess charges, medically necessary emergency
33 care in a foreign country, and the at-home recovery benefit as
34 defined in paragraphs (1), (2), (4), (8), and (10) of subdivision (c)
35 of Section 10192.8, respectively.

36 (9) Standardized Medicare supplement benefit plan H shall
37 consist of only the following: the core benefit, plus the Medicare
38 Part A deductible, skilled nursing facility care, basic outpatient
39 prescription drug benefit, and medically necessary emergency care
40 in a foreign country as defined in paragraphs (1), (2), (6), and (8)

1 of subdivision (c) of Section 10192.8, respectively. The outpatient
2 prescription drug benefit shall not be included in a Medicare
3 supplement policy sold on or after January 1, 2006.

4 (10) Standardized Medicare supplement benefit plan I shall
5 consist of only the following: the core benefit, plus the Medicare
6 Part A deductible, skilled nursing facility care, 100 percent of the
7 Medicare Part B excess charges, basic outpatient prescription drug
8 benefit, medically necessary emergency care in a foreign country,
9 and at-home recovery benefit as defined in paragraphs (1), (2),
10 (5), (6), (8), and (10) of subdivision (c) of Section 10192.8,
11 respectively. The outpatient prescription drug benefit shall not be
12 included in a Medicare supplement policy sold on or after January
13 1, 2006.

14 (11) Standardized Medicare supplement benefit plan J shall
15 consist of only the following: the core benefit, plus the Medicare
16 Part A deductible, skilled nursing facility care, Medicare Part B
17 deductible, 100 percent of the Medicare Part B excess charges,
18 extended outpatient prescription drug benefit, medically necessary
19 emergency care in a foreign country, preventive medical care, and
20 at-home recovery benefit as defined in paragraphs (1), (2), (3),
21 (5), (7), (8), (9), and (10) of subdivision (c) of Section 10192.8,
22 respectively. The outpatient prescription drug benefit shall not be
23 included in a Medicare supplement policy sold on or after January
24 1, 2006.

25 (12) Standardized Medicare supplement benefit high deductible
26 plan J shall consist of only the following: 100 percent of covered
27 expenses following the payment of the annual high deductible plan
28 J deductible. The covered expenses include the core benefit, plus
29 the Medicare Part A deductible, skilled nursing facility care,
30 Medicare Part B deductible, 100 percent of the Medicare Part B
31 excess charges, extended outpatient prescription drug benefit,
32 medically necessary emergency care in a foreign country,
33 preventive medical care benefit, and at-home recovery benefit as
34 defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of
35 subdivision (c) of Section 10192.8, respectively. The annual high
36 deductible plan J deductible shall consist of out-of-pocket expenses,
37 other than premiums, for services covered by the Medicare
38 supplement plan J policy, and shall be in addition to any other
39 specific benefit deductibles. The annual deductible shall be one
40 thousand five hundred dollars (\$1,500) for 1998 and 1999, and

1 shall be based on a calendar year, as adjusted annually thereafter
2 by the secretary to reflect the change in the Consumer Price Index
3 for all urban consumers for the 12-month period ending with
4 August of the preceding year, and rounded to the nearest multiple
5 of ten dollars (\$10). The outpatient prescription drug benefit shall
6 not be included in a Medicare supplement policy sold on or after
7 January 1, 2006.

8 (13) Standardized Medicare supplement benefit plan K shall
9 consist of only those benefits described in subdivision (d) of
10 Section 10192.8.

11 (14) Standardized Medicare supplement benefit plan L shall
12 consist of only those benefits described in subdivision (e) of
13 Section 10192.8.

14 (f) An issuer may, with the prior approval of the commissioner,
15 offer policies or certificates with new or innovative benefits in
16 addition to the benefits provided in a policy or certificate that
17 otherwise complies with the applicable standards. The new or
18 innovative benefits may include benefits that are appropriate to
19 Medicare supplement insurance, that are not otherwise available
20 and that are cost-effective and offered in a manner that is consistent
21 with the goal of simplification of Medicare supplement policies.
22 On and after January 1, 2006, the innovative benefit shall not
23 include an outpatient prescription drug benefit.

24 ~~SEC. 7.~~

25 *SEC. 20.* Section 10192.91 is added to the Insurance Code, to
26 read:

27 10192.91. The following standards are applicable to all
28 Medicare supplement policies or certificates delivered or issued
29 for delivery in this state *with an effective date* on or after June 1,
30 2010. No policy or certificate may be advertised, solicited,
31 delivered, or issued for delivery in this state as a Medicare
32 supplement policy or certificate unless it complies with these
33 benefit plan standards. Benefit plan standards applicable to
34 Medicare supplement policies and certificates issued *with an*
35 *effective date* before June 1, 2010, remain subject to the
36 requirements of Section 10192.9.

37 (a) (1) An issuer shall make available to each prospective
38 policyholder and certificate holder a policy form or certificate form
39 containing only the basic (core) benefits, as defined in subdivision
40 (b) of Section 10192.81.

1 (2) If an issuer makes available any of the additional benefits
2 described in subdivision (c) of Section 10192.81, or offers
3 standardized benefit Plans K or L, as described in paragraphs (8)
4 and (9) of subdivision (e), then the issuer shall make available to
5 each prospective policyholder and certificate holder, in addition
6 to a policy form or certificate form with only the basic core benefits
7 as described in paragraph (1), a policy form or certificate form
8 containing either standardized benefit Plan C, as described in
9 paragraph (3) of subdivision (e), or standardized benefit Plan F,
10 as described in paragraph (5) of subdivision (e).

11 (b) No groups, packages, or combinations of Medicare
12 supplement benefits other than those listed in this section shall be
13 offered for sale in this state, except as may be permitted in
14 subdivision (f) and by Section 10192.10.

15 (c) Benefit plans shall be uniform in structure, language,
16 designation, and format to the standard benefit plans listed in
17 subdivision (e) and conform to the definitions in Section 10192.4.
18 Each benefit shall be structured in accordance with the format
19 provided in subdivisions (b) and (c) of Section 10192.81; or, in
20 the case of plan K or L, in paragraph (8) or (9) of subdivision (e)
21 and list the benefits in the order shown in subdivision (e). For
22 purposes of this section, “structure, language, and format” means
23 style, arrangement, and overall content of a benefit.

24 (d) In addition to the benefit plan designations required in
25 subdivision (c) ~~of this section~~, an issuer may use other designations
26 to the extent permitted by law.

27 (e) With respect to the make-up of 2010 standardized benefit
28 plans, the following shall apply:

29 (1) Standardized Medicare supplement benefit Plan A shall
30 include only the basic (core) benefits as defined in subdivision (b)
31 of Section 10192.81.

32 (2) Standardized Medicare supplement benefit Plan B shall
33 include only the following: the basic (core) benefit as defined in
34 subdivision (b) of Section 10192.81, plus 100 percent of the
35 Medicare Part A deductible as defined in paragraph (1) of
36 subdivision (c) of Section 10192.81.

37 (3) Standardized Medicare supplement benefit Plan C shall
38 include only the following: the basic (core) benefit as defined in
39 subdivision (b) of Section 10192.81, plus 100 percent of the
40 Medicare Part A deductible, skilled nursing facility care, 100

1 percent of the Medicare Part B deductible, and medically necessary
2 emergency care in a foreign country, as defined in paragraphs (1),
3 (3), (4), and (6) of subdivision (c) of Section 10192.81,
4 respectively.

5 (4) Standardized Medicare supplement benefit Plan D shall
6 include only the following: the basic (core) benefit, as defined in
7 subdivision (b) of Section 10192.81, plus 100 percent of the
8 Medicare Part A deductible, skilled nursing facility care, and
9 medically necessary emergency care in a foreign country, as
10 defined in paragraphs (1), (3), and (6) of subdivision (c) of Section
11 10192.81, respectively.

12 (5) Standardized Medicare supplement Plan F shall include only
13 the following: the basic (core) benefit as defined in subdivision
14 (b) of Section 10192.81, plus 100 percent of the Medicare Part A
15 deductible, the skilled nursing facility care, 100 percent of the
16 Medicare Part B deductible, 100 percent of the Medicare Part B
17 excess charges, and medically necessary emergency care in a
18 foreign country as defined in paragraphs (1), (3), (4), (5), and (6)
19 of subdivision (c) of Section 10192.81, respectively.

20 (6) Standardized Medicare supplement Plan F with high
21 deductible shall include only the following: 100 percent of covered
22 expenses following the payment of the annual deductible set forth
23 in subparagraph (B).

24 (A) The covered expenses include the basic (core) benefit as
25 defined in subdivision (b) of Section 10192.81, plus 100 percent
26 of the Medicare Part A deductible, skilled nursing facility care,
27 100 percent of the Medicare Part B deductible, 100 percent of the
28 Medicare Part B excess charges, and medically necessary
29 emergency care in a foreign country, as defined in paragraphs (1),
30 (3), (4), (5), and (6) of subdivision (c) of Section 10192.81,
31 respectively.

32 (B) The annual deductible in Plan F with high deductible shall
33 consist of out-of-pocket expenses, other than premiums, for
34 services covered by Plan F, and shall be in addition to any other
35 specific benefit deductibles. The basis for the deductible shall be
36 one thousand five hundred dollars (\$1,500) and shall be adjusted
37 annually from 1999 by the Secretary of the United States
38 Department of Health and Human Services to reflect the change
39 in the Consumer Price Index for all urban consumers for the

1 12-month period ending with August of the preceding year, and
2 rounded to the nearest multiple of ten dollars (\$10).

3 (7) Standardized Medicare supplement benefit Plan G shall
4 include only the following: the basic (core) benefit as defined in
5 subdivision (b) of Section 10192.81, plus 100 percent of the
6 Medicare Part A deductible, skilled nursing facility care, 100
7 percent of the Medicare Part B excess charges, and medically
8 necessary emergency care in a foreign country, as defined in
9 paragraphs (1), (3), (5), and (6) of subdivision (c) of Section
10 10192.81, respectively.

11 (8) Standardized Medicare supplement Plan K shall include
12 only the following:

13 (A) Coverage of 100 percent of the Part A hospital coinsurance
14 amount for each day used from the 61st through the 90th day in
15 any Medicare benefit period.

16 (B) Coverage of 100 percent of the Part A hospital coinsurance
17 amount for each Medicare lifetime inpatient reserve day used from
18 the 91st through the 150th day in any Medicare benefit period.

19 (C) Upon exhaustion of the Medicare hospital inpatient
20 coverage, including the lifetime reserve days, coverage of 100
21 percent of the Medicare Part A eligible expenses for hospitalization
22 paid at the applicable prospective payment system (PPS) rate, or
23 other appropriate Medicare standard of payment, subject to a
24 lifetime maximum benefit of an additional 365 days. The provider
25 shall accept the issuer's payment as payment in full and may not
26 bill the insured for any balance.

27 (D) Coverage for 50 percent of the Medicare Part A inpatient
28 hospital deductible amount per benefit period until the
29 out-of-pocket limitation is met as described in subparagraph (J).

30 (E) Coverage for 50 percent of the coinsurance amount for each
31 day used from the 21st day through the 100th day in a Medicare
32 benefit period for posthospital skilled nursing facility care eligible
33 under Medicare Part A until the out-of pocket limitation is met as
34 described in subparagraph (J).

35 (F) Coverage for 50 percent of cost sharing for all Part A
36 Medicare eligible expenses and respite care until the out-of pocket
37 limitation is met as described in subparagraph (J).

38 (G) Coverage for 50 percent, under Medicare Part A or B, of
39 the reasonable cost of the first three pints of blood, or equivalent
40 quantities of packed red blood cells, as defined under federal

1 regulations, unless replaced in accordance with federal regulations
2 until the out-of-pocket limitation is met as described in
3 subparagraph (J).

4 (H) Except for coverage provided in subparagraph (I), coverage
5 for 50 percent of the cost sharing otherwise applicable under
6 Medicare Part B after the policyholder pays the Part B deductible
7 until the out-of-pocket limitation is met as described in
8 subparagraph (J).

9 (I) Coverage of 100 percent of the cost sharing for Medicare
10 Part B preventive services after the policyholder pays the Part B
11 deductible.

12 (J) Coverage of 100 percent of all cost sharing under Medicare
13 Parts A and B for the balance of the calendar year after the
14 individual has reached the out-of-pocket limitation on annual
15 expenditures under Medicare Parts A and B of four thousand
16 dollars (\$4,000) in 2006, indexed each year by the appropriate
17 inflation adjustment specified by the Secretary of the United States
18 Department of Health and Human Services.

19 (9) Standardized Medicare supplement Plan L shall include only
20 the following:

21 (A) The benefits described in subparagraphs (A), (B), (C), and
22 (I) of paragraph (8).

23 (B) The benefit described in subparagraphs (D), (E), (F), (G),
24 and (H) of paragraph (8), but substituting 75 percent for 50 percent.

25 (C) The benefit described in subparagraph (J) of paragraph (8),
26 but substituting two thousand dollars (\$2,000) for four thousand
27 dollars (\$4,000).

28 (10) Standardized Medicare supplement Plan M shall include
29 only the following: the basic (core) benefit as defined in
30 subdivision (b) of Section 10192.81, plus 50 percent of the
31 Medicare Part A deductible, skilled nursing facility care, and
32 medically necessary emergency care in a foreign country, as
33 defined in paragraphs (2), (3), and (6) of subdivision (c) of Section
34 10192.81, respectively.

35 (11) Standardized Medicare supplement Plan N shall include
36 only the following: the basic (core) benefit as defined in
37 subdivision (b) of Section 10192.81, plus 100 percent of the
38 Medicare Part A deductible, skilled nursing facility care, and
39 medically necessary emergency care in a foreign country, as

defined in paragraphs (1), (3), and (6) of subdivision (c) of Section 10192.81, respectively, with copayments in the following amounts:

(A) The lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists.

(B) The lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(f) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost effective. Approval of new or innovative benefits shall not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

~~SEC. 8.~~

SEC. 21. Section 10192.11 of the Insurance Code is amended to read:

10192.11. (a) (1) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

(2) An issuer shall make available Medicare supplement benefit plans A, B, C, and F, if currently available, to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease. An issuer shall also make available to those applicants, Medicare supplement benefit plan H, I, or J, if currently available, and commencing January 1, 2007, shall make available to them Medicare supplement benefit plan K or L, if currently available. The selection among Medicare supplement plan H, I, or J and the selection between Medicare supplement benefit plan K or L shall be made at the issuer's discretion.

(3) This section and Section 10192.12 do not prohibit an issuer in determining premium rates from treating applicants who are under 65 years of age and are eligible for Medicare Part B as a separate risk classification. This section shall not be construed as preventing the exclusion of benefits for preexisting conditions as defined in paragraph (1) of subdivision (a) of Section 10192.8 or paragraph (1) of subdivision (a) of Section 10192.81.

(b) (1) If an applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this subdivision shall be as specified by the commissioner.

(c) Except as provided in subdivision (b) and Section 10192.23, subdivision (a) shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(d) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for

1 six months after the date of his or her enrollment in Medicare Part
2 B, or if notified retroactively of his or her eligibility for Medicare,
3 for six months following notice of eligibility. Every issuer shall
4 make available to every applicant qualified for open enrollment
5 all policies and certificates offered by that issuer at the time of
6 application. Issuers shall not discourage sales during the open
7 enrollment period by any means, including the altering of the
8 commission structure.

9 (e) (1) An individual enrolled in Medicare Part B is entitled to
10 open enrollment described in this section for six months following:

11 (A) Receipt of a notice of termination or, if no notice is received,
12 the effective date of termination from any employer-sponsored
13 health plan including an employer-sponsored retiree health plan.

14 (B) Receipt of a notice of loss of eligibility due to the divorce
15 or death of a spouse or, if no notice is received, the effective date
16 of loss of eligibility due to the divorce or death of a spouse, from
17 any employer-sponsored health plan including an
18 employer-sponsored retiree health plan.

19 (C) Termination of health care services for a military retiree or
20 the retiree's Medicare eligible spouse or dependent as a result of
21 a military base closure or loss of access to health care services
22 because the base no longer offers services or because the individual
23 relocates.

24 (2) For purposes of this subdivision, "employer-sponsored retiree
25 health plan" includes any coverage for medical expenses, *including,*
26 *but not limited to, coverage under the Consolidated Omnibus*
27 *Budget Reconciliation Act of 1985 (COBRA) and the California*
28 *Continuation Benefits Replacement Act (Cal-COBRA)*, that is
29 directly or indirectly sponsored or established by an employer for
30 employees or retirees, their spouses, dependents, or other included
31 insureds.

32 (f) An individual enrolled in Medicare Part B is entitled to open
33 enrollment described in this section if the individual was covered
34 under a policy, certificate, or contract providing Medicare
35 supplement coverage but that coverage terminated because the
36 individual established residence at a location not served by the
37 plan.

38 (g) An individual whose coverage was terminated by a Medicare
39 Advantage plan shall be entitled to an additional 60-day open
40 enrollment period to be added on to and run consecutively after

1 any open enrollment period authorized by federal law or regulation,
2 for any Medicare supplement coverage provided by Medicare
3 supplement issuers and available on a guaranteed basis under state
4 and federal law or regulation for persons terminated by their
5 Medicare Advantage plan.

6 (h) An individual shall be entitled to an annual open enrollment
7 period lasting 30 days or more, commencing with the individual's
8 birthday, during which time that person may purchase any
9 Medicare supplement policy that offers benefits equal to or lesser
10 than those provided by the previous coverage. During this open
11 enrollment period, no issuer that falls under this provision shall
12 deny or condition the issuance or effectiveness of Medicare
13 supplement coverage, nor discriminate in the pricing of coverage,
14 because of health status, claims experience, receipt of health care,
15 or medical condition of the individual if, at the time of the open
16 enrollment period, the individual is covered under another
17 Medicare supplement policy or contract. An issuer shall notify a
18 policyholder of his or her rights under this subdivision at least 30
19 and no more than 60 days before the beginning of the open
20 enrollment period.

21 (i) Commencing January 1, 2007, an individual enrolled in
22 Medicare Part B is entitled to open enrollment described in this
23 section upon being notified that he or she is no longer eligible for
24 benefits, including benefits with a share of cost, under the Medi-Cal
25 program because of an increase in the individual's income or assets.

26 ~~SEC. 9:~~

27 *SEC. 22.* Section 10192.12 of the Insurance Code is amended
28 to read:

29 10192.12. (a) (1) With respect to the guaranteed issue of a
30 Medicare supplement policy, eligible persons are those individuals
31 described in subdivision (b) who seek to enroll under the policy
32 during the period specified in subdivision (c), and who submit
33 evidence of the date of termination or disenrollment or enrollment
34 in Medicare Part D with the application for a Medicare supplement
35 policy.

36 (2) With respect to eligible persons, an issuer shall not take any
37 of the following actions:

38 (A) Deny or condition the issuance or effectiveness of a
39 Medicare supplement policy described in subdivision (e) that is
40 offered and is available for issuance to new enrollees by the issuer.

1 (B) Discriminate in the pricing of that Medicare supplement
2 policy because of health status, claims experience, receipt of health
3 care, or medical condition.

4 (C) Impose an exclusion of benefits based on a preexisting
5 condition under that Medicare supplement policy.

6 (b) An eligible person is an individual described in any of the
7 following paragraphs:

8 (1) The individual is enrolled under an employee welfare benefit
9 plan that provides health benefits that supplement the benefits
10 ~~under Medicare, and the plan terminates, or the plan ceases to~~
11 ~~provide some, all, or substantially all of those supplemental health~~
12 ~~benefits to the individual, or the employer no longer provides the~~
13 ~~individual with insurance that covers all of the payment for the~~
14 ~~Part B 20-percent coinsurance; under Medicare, the plan either~~
15 ~~terminates or ceases to provide all of those supplemental health~~
16 ~~benefits to the individual, and the employer no longer provides~~
17 ~~the individual with insurance that covers all of the payment for~~
18 ~~the 20-percent coinsurance.~~

19 (2) The individual is enrolled with a Medicare Advantage
20 organization under a Medicare Advantage plan under Medicare
21 Part C, and any of the following circumstances apply:

22 (A) The certification of the organization or plan has been
23 terminated.

24 (B) The organization has terminated or otherwise discontinued
25 providing the plan in the area in which the individual resides.

26 (C) The individual is no longer eligible to elect the plan because
27 of a change in the individual's place of residence or other change
28 in circumstances specified by the secretary. Those changes in
29 circumstances shall not include termination of the individual's
30 enrollment on the basis described in Section 1851(g)(3)(B) of the
31 federal Social Security Act where the individual has not paid
32 premiums on a timely basis or has engaged in disruptive behavior
33 as specified in standards under Section 1856, or the plan is
34 terminated for all individuals within a residence area.

35 (D) The Medicare Advantage plan in which the individual is
36 enrolled reduces any of its benefits or increases the amount of cost
37 sharing or discontinues for other than good cause relating to quality
38 of care, its relationship or contract under the plan with a provider
39 who is currently furnishing services to the individual. An individual
40 shall be eligible under this subparagraph for a Medicare supplement

1 policy issued by the same issuer through which the individual was
2 enrolled at the time the reduction, increase, or discontinuance
3 described above occurs or, commencing January 1, 2007, for one
4 issued by a subsidiary of the parent company of that issuer or by
5 a network that contracts with the parent company of that issuer.

6 (E) The individual demonstrates, in accordance with guidelines
7 established by the secretary, either of the following:

8 (i) The organization offering the plan substantially violated a
9 material provision of the organization's contract under this article
10 in relation to the individual, including the failure to provide on a
11 timely basis medically necessary care for which benefits are
12 available under the plan or the failure to provide the covered care
13 in accordance with applicable quality standards.

14 (ii) The organization, or agent or other entity acting on the
15 organization's behalf, materially misrepresented the plan's
16 provisions in marketing the plan to the individual.

17 (F) The individual meets other exceptional conditions as the
18 secretary may provide.

19 (3) The individual is 65 years of age or older, is enrolled with
20 a Program of All-Inclusive Care for the Elderly (PACE) provider
21 under Section 1894 of the Social Security Act, and circumstances
22 similar to those described in paragraph (2) exist that would permit
23 discontinuance of the individual's enrollment with the provider,
24 if the individual were enrolled in a Medicare Advantage plan.

25 (4) The individual meets both of the following conditions:

26 (A) The individual is enrolled with any of the following:

27 (i) An eligible organization under a contract under Section 1876
28 of the Social Security Act (Medicare cost).

29 (ii) A similar organization operating under demonstration project
30 authority, effective for periods before April 1, 1999.

31 (iii) An organization under an agreement under Section
32 1833(a)(1)(A) of the Social Security Act (health care prepayment
33 plan).

34 (iv) An organization under a Medicare Select policy.

35 (B) The enrollment ceases under the same circumstances that
36 would permit discontinuance of an individual's election of coverage
37 under paragraph (2) or (3).

38 (5) The individual is enrolled under a Medicare supplement
39 policy, and the enrollment ceases because of any of the following
40 circumstances:

1 (A) The insolvency of the issuer or bankruptcy of the nonissuer
2 organization, or other involuntary termination of coverage or
3 enrollment under the policy.

4 (B) The issuer of the policy substantially violated a material
5 provision of the policy.

6 (C) The issuer, or an agent or other entity acting on the issuer's
7 behalf, materially misrepresented the policy's provisions in
8 marketing the policy to the individual.

9 (6) The individual meets both of the following conditions:

10 (A) The individual was enrolled under a Medicare supplement
11 policy and terminates enrollment and subsequently enrolls, for the
12 first time, with any Medicare Advantage organization under a
13 Medicare Advantage plan under Medicare Part C, any eligible
14 organization under a contract under Section 1876 of the Social
15 Security Act (Medicare cost), any similar organization operating
16 under demonstration project authority, any PACE provider under
17 Section 1894 of the Social Security Act, or a Medicare Select
18 policy.

19 (B) The subsequent enrollment under subparagraph (A) is
20 terminated by the individual during any period within the first 12
21 months of the subsequent enrollment (during which the enrollee
22 is permitted to terminate the subsequent enrollment under Section
23 1851(e) of the federal Social Security Act).

24 (7) The individual upon first becoming eligible for benefits
25 under Medicare Part A at age 65 years of age, enrolls in a Medicare
26 Advantage plan under Medicare Part C or with a PACE provider
27 under Section 1894 of the Social Security Act, and disenrolls from
28 the plan or program not later than 12 months after the effective
29 date of enrollment.

30 (8) The individual while enrolled under a Medicare supplement
31 policy that covers outpatient prescription drugs enrolls in a
32 Medicare Part D plan during the initial enrollment period,
33 terminates enrollment in the Medicare supplement policy, and
34 submits evidence of enrollment in Medicare Part D along with the
35 application for a policy described in paragraph (4) of subdivision
36 (e).

37 (c) (1) In the case of an individual described in paragraph (1)
38 of subdivision (b), the guaranteed issue period begins on the later
39 of the following two dates and ends on the date that is 63 days
40 after the date the applicable coverage terminates:

1 (A) The date the individual receives a notice of termination or
2 cessation of all supplemental health benefits or, if no notice is
3 received, the date of the notice denying a claim because of a
4 termination or cessation of benefits.

5 (B) The date that the applicable coverage terminates or ceases.

6 (2) In the case of an individual described in paragraphs (2), (3),
7 (4), (6), and (7) of subdivision (b) whose enrollment is terminated
8 involuntarily, the guaranteed issue period begins on the date that
9 the individual receives a notice of termination and ends 63 days
10 after the date the applicable coverage is terminated.

11 (3) In the case of an individual described in subparagraph (A)
12 of paragraph (5) of subdivision (b), the guaranteed issue period
13 begins on the earlier of the following two dates and ends on the
14 date that is 63 days after the date the coverage is terminated:

15 (A) The date that the individual receives a notice of termination,
16 a notice of the issuer's bankruptcy or insolvency, or other similar
17 notice if any.

18 (B) The date that the applicable coverage is terminated.

19 (4) In the case of an individual described in paragraph (2), (3),
20 (6), or (7) of, or in subparagraph (B) or (C) of paragraph (5) of,
21 subdivision (b) who disenrolls voluntarily, the guaranteed issue
22 period begins on the date that is 60 days before the effective date
23 of the disenrollment and ends on the date that is 63 days after the
24 effective date of the disenrollment.

25 (5) In the case of an individual described in paragraph (8) of
26 subdivision (b), the guaranteed issue period begins on the date the
27 individual receives notice pursuant to Section 1882(v)(2)(B) of
28 the Social Security Act from the Medicare supplement issuer during
29 the 60-day period immediately preceding the initial enrollment
30 period for Medicare Part D and ends on the date that is 63 days
31 after the effective date of the individual's coverage under Medicare
32 Part D.

33 (6) In the case of an individual described in subdivision (b) who
34 is not included in this subdivision, the guaranteed issue period
35 begins on the effective date of disenrollment and ends on the date
36 that is 63 days after the effective date of disenrollment.

37 (d) (1) In the case of an individual described in paragraph (6)
38 of subdivision (b), or deemed to be so described pursuant to this
39 paragraph, whose enrollment with an organization or provider
40 described in subparagraph (A) of paragraph (6) of subdivision (b)

1 is involuntarily terminated within the first 12 months of enrollment
2 and who, without an intervening enrollment, enrolls with another
3 such organization or provider, the subsequent enrollment shall be
4 deemed to be an initial enrollment described in paragraph (6) of
5 subdivision (b).

6 (2) In the case of an individual described in paragraph (7) of
7 subdivision (b), or deemed to be so described pursuant to this
8 paragraph, whose enrollment with a plan or in a program described
9 in paragraph (7) of subdivision (b) is involuntarily terminated
10 within the first 12 months of enrollment and who, without an
11 intervening enrollment, enrolls in another such plan or program,
12 the subsequent enrollment shall be deemed to be an initial
13 enrollment described in paragraph (7) of subdivision (b).

14 (3) For purposes of paragraphs (6) and (7) of subdivision (b),
15 an enrollment of an individual with an organization or provider
16 described in subparagraph (A) of paragraph (6) of subdivision (b),
17 or with a plan or in a program described in paragraph (7) of
18 subdivision (b) shall not be deemed to be an initial enrollment
19 under this paragraph after the two-year period beginning on the
20 date on which the individual first enrolled with such an
21 organization, provider, plan, or program.

22 (e) (1) Under paragraphs (1), (2), (3), (4), and (5) of subdivision
23 (b), an eligible individual is entitled to a Medicare supplement
24 policy that has a benefit package classified as Plan A, B, C, F
25 (including a high deductible Plan F), K, or L offered by any issuer.

26 (2) (A) Under paragraph (6) of subdivision (b), an eligible
27 individual is entitled to the same Medicare supplement policy in
28 which he or she was most recently enrolled, if available from the
29 same issuer. If that policy is not available, the eligible individual
30 is entitled to a Medicare supplement policy that has a benefit
31 package classified as Plan A, B, C, F (including a high deductible
32 Plan F), K, or L offered by any issuer.

33 (B) On and after January 1, 2006, an eligible individual
34 described in this paragraph who was most recently enrolled in a
35 Medicare supplement policy with an outpatient prescription drug
36 benefit, is entitled to a Medicare supplement policy that is available
37 from the same issuer but without an outpatient prescription drug
38 benefit or, at the election of the individual, has a benefit package
39 classified as a Plan A, B, C, F (including high deductible Plan F),
40 K, or L that is offered by any issuer.

1 (3) Under paragraph (7) of subdivision (b), an eligible individual
2 is entitled to any Medicare supplement policy offered by any issuer.

3 (4) Under paragraph (8) of subdivision (b), an eligible individual
4 is entitled to a Medicare supplement policy that has a benefit
5 package classified as Plan A, B, C, F (including a high deductible
6 Plan F), K, or L and that is offered and is available for issuance to
7 a new enrollee by the same issuer that issued the individual's
8 Medicare supplement policy with outpatient prescription drug
9 coverage.

10 (f) (1) At the time of an event described in subdivision (b) by
11 which an individual loses coverage or benefits due to the
12 termination of a contract or agreement, policy, or plan, the
13 organization that terminates the contract or agreement, the issuer
14 terminating the policy, or the administrator of the plan being
15 terminated, respectively, shall notify the individual of his or her
16 rights under this section and of the obligations of issuers of
17 Medicare supplement policies under subdivision (a). The notice
18 shall be communicated contemporaneously with the notification
19 of termination.

20 (2) At the time of an event described in subdivision (b) by which
21 an individual ceases enrollment under a contract or agreement,
22 policy, or plan, the organization that offers the contract or
23 agreement, regardless of the basis for the cessation of enrollment,
24 the issuer offering the policy, or the administrator of the plan,
25 respectively, shall notify the individual of his or her rights under
26 this section, and of the obligations of issuers of Medicare
27 supplement policies under subdivision (a). The notice shall be
28 communicated within 10 working days of the date the issuer
29 received notification of disenrollment.

30 (g) An issuer shall refund any unearned premium that an insured
31 paid in advance and shall terminate coverage upon the request of
32 an insured.

33 ~~SEC. 10.~~

34 *SEC. 23.* Section 10192.13 of the Insurance Code is amended
35 to read:

36 10192.13. (a) An issuer shall comply with Section 1882(c)(3)
37 of the federal Social Security Act (as enacted by Section
38 4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act
39 of 1987 (OBRA), Public Law 100-203) by doing all of the

1 following and by certifying compliance on the Medicare
2 supplement insurance experience reporting form:

3 (1) Accepting a notice from a Medicare—administrative
4 contractor, formally known as a fiscal intermediary or carrier,
5 *Administrative Contractor, formerly known as a fiscal intermediary*
6 *or carrier*, on dually assigned claims submitted by participating
7 physicians and suppliers as a claim for benefits in place of any
8 other claim form otherwise required and making a payment
9 determination on the basis of the information contained in that
10 notice.

11 (2) Notifying the participating physician or supplier and the
12 beneficiary of the payment determination.

13 (3) Paying the participating physician or supplier directly.

14 (4) Furnishing, at the time of enrollment, each enrollee with a
15 card listing the policy name, number, and a central mailing address
16 to which notices from a Medicare—administrative contractors
17 *Administrative Contractors* may be sent.

18 (5) Paying user fees for claim notices that are transmitted
19 electronically or otherwise.

20 (6) Providing to the secretary, at least annually, a central mailing
21 address to which all claims may be sent by Medicare—administrative
22 contractors *Administrative Contractors*.

23 (7) File, by June 30 of each year, with the commissioner a list
24 of its Medicare supplement policies and certificates offered or
25 issued or in force in California as of the end of the previous year.

26 (A) The list shall identify the issuer by name and address, shall
27 identify each type of form it offers by name and form number, and
28 shall differentiate between forms approved in the previous calendar
29 year and those approved before the previous calendar year.

30 (B) The list shall identify all of the following:

31 (i) Forms issued and in force but no longer offered in California.

32 (ii) Forms that, for any reason, were not filed and approved by
33 the commissioner.

34 (iii) Forms for which the commissioner's approval was
35 withdrawn within the previous calendar year.

36 (iv) The number of forms issued in California in the previous
37 calendar year, and the number of forms in force in California on
38 December 31 of the previous calendar year.

(b) (1) Compliance with the requirements set forth in subdivision (a) shall be certified on the Medicare supplement insurance experience reporting form provided by the commissioner.

(2) The commissioner shall, by September 1 of each year, provide the secretary with a list identifying each issuer by name and address and provide the information requested in this section.

(c) No issuer that administers Medicare coverage and federal employee programs may require that more than one form be submitted per claim in order to receive payment or reimbursement under any or all of those policies or programs.

~~SEC. 11.~~

SEC. 24. Section 10192.17 of the Insurance Code is amended to read:

10192.17. (a) Medicare supplement policies and certificates shall include a renewal, continuation, or conversion provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(b) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after the date of issue or upon reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(c) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual

1 and customary,” “reasonable and customary,” or words of similar
2 import.

3 (d) If a Medicare supplement policy or certificate contains any
4 limitations with respect to preexisting conditions, those limitations
5 shall appear as a separate paragraph of the policy and be labeled
6 as “Preexisting Condition Limitations.”

7 (e) (1) Medicare supplement policies and certificates shall have
8 a notice prominently printed on the first page of the policy or
9 certificate, and of the outline of coverage, or attached thereto, in
10 no less than 10-point uppercase type, stating in substance that the
11 policyholder or certificate holder shall have the right to return the
12 policy or certificate, via regular mail, within 30 days of receiving
13 it, and to have the full premium refunded if, after examination of
14 the policy or certificate, the insured person is not satisfied for any
15 reason. The return shall void the contract from the beginning, and
16 the parties shall be in the same position as if no contract had been
17 issued.

18 (2) For purposes of this section, a timely manner shall be no
19 later than 30 days after the issuer receives the returned contract.

20 (3) If the issuer fails to refund all prepaid or periodic charges
21 paid in a timely manner, then the applicant shall receive interest
22 on the paid charges at the legal rate of interest on judgments as
23 provided in Section 685.010 of the Code of Civil Procedure. The
24 interest shall be paid from the date the issuer received the returned
25 contract.

26 (f) (1) Issuers of health insurance policies, certificates, or
27 contracts that provide hospital or medical expense coverage on an
28 expense incurred or indemnity basis, other than incidentally, to
29 persons eligible for Medicare shall provide to those applicants a
30 Guide to Health Insurance for People with Medicare in the form
31 developed jointly by the National Association of Insurance
32 Commissioners and the Centers for Medicare and Medicaid
33 Services and in a type size no smaller than 12-point type. Delivery
34 of the guide shall be made whether or not the policies or certificates
35 are advertised, solicited, or issued for delivery as Medicare
36 supplement policies or certificates as defined in this article. Except
37 in the case of direct response issuers, delivery of the guide shall
38 be made to the applicant at the time of application, and
39 acknowledgment of receipt of the guide shall be obtained by the
40 issuer. Direct response issuers shall deliver the guide to the

1 applicant upon request, but not later than at the time the policy is
2 delivered.

3 (2) For the purposes of this section, “form” means the language,
4 format, type size, type proportional spacing, bold character, and
5 line spacing.

6 (g) As soon as practicable, but no later than 30 days prior to the
7 annual effective date of any Medicare benefit changes, an issuer
8 shall notify its policyholders and certificate holders of
9 modifications it has made to Medicare supplement policies or
10 certificates in a format acceptable to the commissioner. The notice
11 shall include both of the following:

12 (1) A description of revisions to the Medicare Program and a
13 description of each modification made to the coverage provided
14 under the Medicare supplement policy or certificate.

15 (2) Inform each policyholder or certificate holder as to when
16 any premium adjustment is to be made due to changes in Medicare.

17 (h) The notice of benefit modifications and any premium
18 adjustments shall be in outline form and in clear and simple terms
19 so as to facilitate comprehension.

20 (i) The notices shall not contain or be accompanied by any
21 solicitation.

22 (j) (1) Issuers shall provide an outline of coverage to all
23 applicants at the time application is presented to the prospective
24 applicant and, except for direct response policies, shall obtain an
25 acknowledgment of receipt of the outline from the applicant. If an
26 outline of coverage is provided at the time of application and the
27 Medicare supplement policy or certificate is issued on a basis
28 which would require revision of the outline, a substitute outline
29 of coverage properly describing the policy or certificate shall
30 accompany the policy or certificate when it is delivered and contain
31 the following statement, in no less than 12-point type, immediately
32 above the company name:

33
34 “NOTICE: Read this outline of coverage carefully. It is not
35 identical to the outline of coverage provided upon application and
36 the coverage originally applied for has not been issued.”
37

38 (2) The outline of coverage provided to applicants pursuant to
39 this section consists of four parts: a cover page, premium
40 information, disclosure pages, and charts displaying the features

1 of each benefit plan offered by the issuer. The outline of coverage
2 shall be in the language and format prescribed below in no less
3 than 12-point type. All Medicare supplement plans authorized by
4 federal law shall be shown on the cover page, and the plans that
5 are offered by the issuer shall be prominently identified. Premium
6 information for plans that are offered shall be shown on the cover
7 page or immediately following the cover page and shall be
8 prominently displayed. The premium and mode shall be stated for
9 all plans that are offered to the prospective applicant. All possible
10 premiums for the prospective applicant shall be illustrated.

11 (3) The commissioner may adopt regulations to implement this
12 article, including, but not limited to, regulations that specify the
13 required information to be contained in the outline of coverage
14 provided to applicants pursuant to this section, including the format
15 of tables, charts, and other information.

16 (k) (1) Any disability insurance policy or certificate, a basic,
17 catastrophic or major medical expense policy, or single premium
18 nonrenewal policy or certificate issued to persons eligible for
19 Medicare, other than a Medicare supplement policy, a policy issued
20 pursuant to a contract under Section 1876 of the federal Social
21 Security Act (42 U.S.C. Sec. 1395 et seq.), a disability income
22 policy, or any other policy identified in subdivision (b) of Section
23 10192.3, advertised, solicited, or issued for delivery in this state
24 to persons eligible for Medicare, shall notify insureds under the
25 policy that the policy is not a Medicare supplement policy or
26 certificate. The notice shall either be printed or attached to the first
27 page of the outline of coverage delivered to insureds under the
28 policy, or if no outline of coverage is delivered, to the first page
29 of the policy or certificate delivered to insureds. The notice shall
30 be in no less than 12-point type and shall contain the following
31 language:

32
33 “THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE
34 SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible
35 for Medicare, review the Guide to Health Insurance for People
36 with Medicare available from the company.”
37

38 (2) Applications provided to persons eligible for Medicare for
39 the disability insurance policies or certificates described in
40 paragraph (1) shall disclose the extent to which the policy

1 duplicates Medicare in a manner required by the commissioner.
2 The disclosure statement shall be provided as a part of, or together
3 with, the application for the policy or certificate.

4 (I) (1) Insurers issuing Medicare supplement policies or
5 certificates for delivery in California shall provide an outline of
6 coverage to all applicants at the time of presentation for
7 examination or sale as provided in Section 10605, and in no case
8 later than at the time the application is made. Except for direct
9 response policies, insurers shall obtain a written acknowledgment
10 of receipt of the outline from the applicant.

11 Any advertisement that is not a presentation for examination or
12 sale as defined in subdivision (e) of Section 10601 shall contain
13 a notice in no less than 10-point uppercase type that an outline of
14 coverage is available upon request. The insurer or agent that
15 receives any request for an outline of coverage shall provide an
16 outline of coverage to the person making the request within 14
17 days of receipt of the request.

18 (2) If an outline of coverage is provided at or before the time
19 of application and the Medicare supplement policy or certificate
20 is issued on a basis that would require revision of the outline, a
21 substitute outline of coverage properly describing the policy or
22 certificate shall accompany the policy or certificate when it is
23 delivered and contain the following statement, in no less than
24 12-point type, immediately above the name:

25
26 “NOTICE: Read this outline of coverage carefully. It is not
27 identical to the outline of coverage provided upon application and
28 the coverage originally applied for has not been issued.”
29

30 (3) The outline of coverage shall be in the language and format
31 prescribed in this subdivision in no less than 12-point type, and
32 shall include the following items in the order prescribed below.
33 Titles, as set forth below in paragraphs (B) to (H), inclusive, shall
34 be capitalized, centered, and printed in boldface type.

35 (A) (i) The following shall only apply to policies sold for
36 effective dates prior to June 1, 2010:

37 (I) The outline of coverage shall include the items, and in the
38 same order, specified in the chart set forth in Section 17 of the
39 Model Regulation to implement the NAIC Medicare Supplement

1 Insurance Minimum Standards Model Act, as adopted by the
2 National Association of Insurance Commissioners in 2004.

3 (II) The cover page shall contain the 12-plan (A-L) charts. The
4 plans offered by the insurer shall be clearly identified. Innovative
5 benefits shall be explained in a manner approved by the
6 commissioner. The text shall read:

7
8 “Medicare supplement insurance can be sold in only 12 standard
9 plans. This chart shows the benefits included in each plan. Every
10 insurance company must offer Plan A. Some plans may not be
11 available.

12 The BASIC BENEFITS included in ALL plans are:

13 Hospitalization: Medicare Part A coinsurance plus coverage for
14 365 additional days after Medicare benefits end.

15 Medical expenses: Medicare Part B coinsurance (usually 20
16 percent of the Medicare-approved amount).

17 Blood: First three pints of blood each year.

18 Mammogram: One annual screening to the extent not covered
19 by Medicare.

20 Cervical cancer test: One annual screening.”

21
22 *[Reference to the mammogram and cervical cancer screening*
23 *test shall not be included so long as California is required to*
24 *disallow them for Medicare beneficiaries by the Centers for*
25 *Medicare and Medicaid Services or other agent of the federal*
26 *government under 42 U.S.C. Sec. 1395ss.]*

27 (ii) The following shall only apply to policies sold for effective
28 dates on or after June 1, 2010:

29 (I) The outline of coverage shall include the items, and in the
30 same order specified in the chart set forth in Section 17 of the
31 Model Regulation to implement the NAIC Medicare Supplement
32 Insurance Minimum Standards Model Act, as adopted by the
33 National Association of Insurance Commissioners in 2008.

34 (II) The cover page shall contain all Medicare supplement plan
35 charts A to D, inclusive, F, F with high deductible, G, and K to N,
36 inclusive. The plans offered by the insurer shall be clearly
37 identified. Innovative benefits shall be explained in a manner
38 approved by the commissioner. The text shall read:

1 “Medicare supplement insurance can be sold in only standard
2 plans. This chart shows the benefits included in each plan. Every
3 insurance company must offer Plan A. Some plans may not be
4 available. Plans E, H, I and J are no longer available for sale. [This
5 sentence shall not appear after June 1, 2011.]

6 The BASIC BENEFITS included in ALL plans are:

7 Hospitalization: Medicare Part A coinsurance plus coverage for
8 365 additional days after Medicare benefits end.

9 Medical expenses: Medicare Part B coinsurance (usually 20
10 percent of the Medicare-approved amount) or copayments for
11 hospital outpatient services. Plans K, L, and N require insureds to
12 pay a portion of Part B coinsurance copayments.

13 Blood: First three pints of blood each year.

14 Hospice: Part A coinsurance.

15 Mammogram: One annual screening to the extent not covered
16 by Medicare.

17 Cervical cancer test: One annual screening.”

18
19 *[Reference to the mammogram and cervical cancer screening*
20 *test shall not be included so long as California is required to*
21 *disallow them for Medicare beneficiaries by the Centers for*
22 *Medicare and Medicaid Services or other agent of the federal*
23 *government under 42 U.S.C. Sec. 1395ss.]*

24 (B) PREMIUM INFORMATION. Premium information for
25 plans that are offered by the insurer shall be shown on, or
26 immediately following, the cover page and shall be clearly and
27 prominently displayed. The premium and mode shall be stated for
28 all offered plans. All possible premiums for the prospective
29 applicant shall be illustrated in writing. If the premium is based
30 on the increasing age of the insured, information specifying when
31 and how premiums will change shall be clearly illustrated in
32 writing. The text shall state: “We [the insurer’s name] can only
33 raise your premium if we raise the premium for all policies like
34 yours in California.”

35 (C) The text shall state: “Use this outline to compare benefits
36 and premiums among policies.”

37 (D) READ YOUR POLICY VERY CAREFULLY. The text
38 shall state: “This is only an outline describing your policy’s most
39 important features. The policy is your insurance contract. You

1 must read the policy itself to understand all of the rights and duties
2 of both you and your insurance company.”

3 (E) THIRTY-DAY RIGHT TO RETURN THIS POLICY. The
4 text shall state: “If you find that you are not satisfied with your
5 policy, you may return it to [insert the insurer’s address]. If you
6 send the policy back to us within 30 days after you receive it, we
7 will treat the policy as if it has never been issued and return all of
8 your payments.”

9 (F) POLICY REPLACEMENT. The text shall read: “If you are
10 replacing another health insurance policy, do NOT cancel it until
11 you have actually received your new policy and are sure you want
12 to keep it.”

13 (G) DISCLOSURES. The text shall read: “This policy may not
14 fully cover all of your medical costs.” “Neither this company nor
15 any of its agents are connected with Medicare.” “This outline of
16 coverage does not give all the details of Medicare coverage.
17 Contact your local social security office or consult ‘The Medicare
18 Handbook’ for more details.” “For additional information
19 concerning policy benefits, contact the Health Insurance
20 Counseling and Advocacy Program (HICAP) or your agent. Call
21 the HICAP toll-free telephone number, 1-800-434-0222, for a
22 referral to your local HICAP office. HICAP is a service provided
23 free of charge by the State of California.”

24 For policies effective on dates on or after June 1, 2010, the
25 following language shall be required until June 1, 2011, “This
26 outline shows benefits and premiums of policies sold for effective
27 dates on or after June 1, 2010. Policies sold for effective dates
28 prior to June 1, 2010 have different benefits and premiums. Plans
29 E, H, I, and J are no longer available for sale.”

30 (H) [For policies that are not guaranteed issue] COMPLETE
31 ANSWERS ARE IMPORTANT. The text shall read: “When you
32 fill out the application for a new policy, be sure to answer truthfully
33 and completely all questions about your medical and health history.
34 The company may have the right to cancel your policy and refuse
35 to pay any claims if you leave out or falsify important medical
36 information.

37 Review the application carefully before you sign it. Be certain
38 that all information has been properly recorded.”

39 (I) One chart for each benefit plan offered by the insurer
40 showing the services, Medicare payments, payments under the

1 policy and payments expected from the insured, using the same
2 uniform format and language. No more than four plans may be
3 shown on one page. Include an explanation of any innovative
4 benefits in a manner approved by the commissioner.

5 (m) An issuer shall comply with all notice requirements of the
6 Medicare Prescription Drug, Improvement, and Modernization
7 Act of 2003 (P.L. 108-173).

8 ~~SEC. 12.~~

9 *SEC. 25.* Section 10192.18 of the Insurance Code is amended
10 to read:

11 10192.18. (a) Application forms shall include the following
12 questions designed to elicit information as to whether, as of the
13 date of the application, the applicant currently has Medicare
14 supplement, Medicare Advantage, Medi-Cal coverage, or another
15 health insurance policy or certificate in force or whether a Medicare
16 supplement policy or certificate is intended to replace any other
17 disability policy or certificate presently in force. A supplementary
18 application or other form to be signed by the applicant and agent
19 containing those questions and statements may be used.

20
21 (Statements)

22
23 (1) You do not need more than one Medicare supplement policy.

24 (2) If you purchase this policy, you may want to evaluate your
25 existing health coverage and decide if you need multiple coverages.

26 (3) You may be eligible for benefits under Medi-Cal and may
27 not need a Medicare supplement policy.

28 (4) If after purchasing this policy you become eligible for
29 Medi-Cal, the benefits and premiums under your Medicare
30 supplement policy can be suspended, if requested, during your
31 entitlement to benefits under Medi-Cal for 24 months. You must
32 request this suspension within 90 days of becoming eligible for
33 Medi-Cal. If you are no longer entitled to Medi-Cal, your
34 suspended Medicare supplement policy or if that is no longer
35 available, a substantially equivalent policy, will be reinstituted if
36 requested within 90 days of losing Medi-Cal eligibility. If the
37 Medicare supplement policy provided coverage for outpatient
38 prescription drugs and you enrolled in Medicare Part D while your
39 policy was suspended, the reinstituted policy will not have
40 outpatient prescription drug coverage, but will otherwise be

1 substantially equivalent to your coverage before the date of the
2 suspension.

3 (5) If you are eligible for, and have enrolled in, a Medicare
4 supplement policy by reason of disability and you later become
5 covered by an employer or union-based group health plan, the
6 benefits and premiums under your Medicare supplement policy
7 can be suspended, if requested, while you are covered under the
8 employer or union-based group health plan. If you suspend your
9 Medicare supplement policy under these circumstances and later
10 lose your employer or union-based group health plan, your
11 suspended Medicare supplement policy or if that is no longer
12 available, a substantially equivalent policy, will be reinstituted if
13 requested within 90 days of losing your employer or union-based
14 group health plan. If the Medicare supplement policy provided
15 coverage for outpatient prescription drugs and you enrolled in
16 Medicare Part D while your policy was suspended, the reinstituted
17 policy will not have outpatient prescription drug coverage, but will
18 otherwise be substantially equivalent to your coverage before the
19 date of the suspension.

20 (6) Counseling services are available in this state to provide
21 advice concerning your purchase of Medicare supplement insurance
22 and concerning medical assistance through the Medi-Cal program,
23 including benefits as a qualified Medicare beneficiary (QMB) and
24 a specified low-income Medicare beneficiary (SLMB). If you want
25 to discuss buying Medicare supplement insurance with a trained
26 insurance counselor, call the California Department of Insurance's
27 toll-free telephone number 1-800-927-HELP, and ask how to
28 contact your local Health Insurance Counseling and Advocacy
29 Program (HICAP) office. HICAP is a service provided free of
30 charge by the State of California.

31
32 (Questions)

33
34 If you lost or are losing other health insurance coverage and
35 received a notice from your prior insurer saying you were eligible
36 for guaranteed issue of a Medicare supplement insurance policy
37 or that you had certain rights to buy such a policy, you may be
38 guaranteed acceptance in one or more of our Medicare supplement
39 plans. Please include a copy of the notice from your prior insurer
40 with your application. PLEASE ANSWER ALL QUESTIONS.

- 1 [Please mark Yes or No below with an “X.”]
2 To the best of your knowledge,
3 (1) (a) Did you turn 65 years of age in the last 6 months
4 Yes____ No____
5 (b) Did you enroll in Medicare Part B in the last 6 months
6 Yes____ No____
7 (c) If yes, what is the effective date _____
8 (2) Are you covered for medical assistance through California’s
9 Medi-Cal program
10 NOTE TO APPLICANT: If you have a share of cost under the
11 Medi-Cal program, please answer NO to this question.
12 Yes____ No____
13 If yes,
14 (a) Will Medi-Cal pay your premiums for this Medicare
15 supplement policy
16 Yes____ No____
17 (b) Do you receive benefits from Medi-Cal OTHER THAN
18 payments toward your Medicare Part B premium
19 Yes____ No____
20 (3) (a) If you had coverage from any Medicare plan other than
21 original Medicare within the past 63 days (for example, a Medicare
22 Advantage plan or a Medicare HMO or PPO), fill in your start and
23 end dates below. If you are still covered under this plan, leave
24 “END” blank.
25 START __/__/__ END __/__/__
26 (b) If you are still covered under the Medicare plan, do you
27 intend to replace your current coverage with this new Medicare
28 supplement policy
29 Yes____ No____
30 (c) Was this your first time in this type of Medicare plan
31 Yes____ No____
32 (d) Did you drop a Medicare supplement policy to enroll in the
33 Medicare plan
34 Yes____ No____
35 (4) (a) Do you have another Medicare supplement policy in
36 force
37 Yes____ No____
38 (b) If so, with what company, and what plan do you have
39 [optional for direct mailers]
40 Yes____ No____

1 (c) If so, do you intend to replace your current Medicare
2 supplement policy with this policy

3 Yes____ No____

4 (5) Have you had coverage under any other health insurance
5 within the past 63 days (For example, an employer, union, or
6 individual plan)

7 Yes____ No____

8 (a) If so, with what companies and what kind of policy

9 _____
10 _____
11 _____
12 _____

13 (b) What are your dates of coverage under the other policy

14 START __/__/__ END __/__/__

15 (If you are still covered under the other policy, leave “END”
16 blank.)

17
18 ~~(e)~~

19 (b) Agents shall list any other health insurance policies they
20 have sold to the applicant as follows:

21 (1) List policies sold that are still in force.

22 (2) List policies sold in the past five years that are no longer in
23 force.

24 ~~(d)~~

25 (c) In the case of a direct response issuer, a copy of the
26 application or supplemental form, signed by the applicant, and
27 acknowledged by the issuer, shall be returned to the applicant by
28 the issuer upon delivery of the policy.

29 ~~(e)~~

30 (d) Upon determining that a sale will involve replacement of
31 Medicare supplement coverage, any issuer, other than a direct
32 response issuer, or its agent, shall furnish the applicant, prior to
33 issuance for delivery of the Medicare supplement policy or
34 certificate, a notice regarding replacement of Medicare supplement
35 coverage. One copy of the notice signed by the applicant and the
36 agent, except where the coverage is sold without an agent, shall
37 be provided to the applicant and an additional signed copy shall
38 be retained by the issuer as provided in Section 10508. A direct
39 response issuer shall deliver to the applicant at the time of the

1 issuance of the policy the notice regarding replacement of Medicare
2 supplement coverage.

3 ~~(f)~~

4 (e) The notice required by subdivision (e) for an issuer shall be
5 in the form specified by the commissioner, using, to the extent
6 practicable, a model notice prepared by the National Association
7 of Insurance Commissioners for this purpose. The replacement
8 notice shall be printed in no less than 12-point type in substantially
9 the following form:

10
11 [Insurer's name and address]
12

13 NOTICE TO APPLICANT REGARDING REPLACEMENT
14 OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE
15 ADVANTAGE
16

17 SAVE THIS NOTICE! IT MAY BE IMPORTANT IN THE
18 FUTURE.

19 If you intend to cancel or terminate existing Medicare supplement
20 or Medicare Advantage insurance and replace it with coverage
21 issued by [company name], please review the new coverage
22 carefully and replace the existing coverage ONLY if the new
23 coverage materially improves your position. DO NOT CANCEL
24 YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED
25 YOUR NEW POLICY AND ARE SURE THAT YOU WANT
26 TO KEEP IT.

27 If you decide to purchase the new coverage, you will have 30
28 days after you receive the policy to return it to the insurer, for any
29 reason, and receive a refund of your money.

30 If you want to discuss buying Medicare supplement or Medicare
31 Advantage coverage with a trained insurance counselor, call the
32 California Department of Insurance's toll-free telephone number
33 1-800-927-HELP, and ask how to contact your local Health
34 Insurance Counseling and Advocacy Program (HICAP) office.
35 HICAP is a service provided free of charge by the State of
36 California.

37 STATEMENT TO APPLICANT FROM THE INSURER AND
38 AGENT: I have reviewed your current health insurance coverage.
39 To the best of my knowledge, the replacement of insurance
40 involved in this transaction does not duplicate coverage or, if

1 applicable, Medicare Advantage coverage because you intend to
2 terminate your existing Medicare supplement coverage or leave
3 your Medicare Advantage plan. In addition, the replacement
4 coverage contains benefits that are clearly and substantially greater
5 than your current benefits for the following reasons:

6 ___ Additional benefits that are: _____

7 ___ No change in benefits, but lower premiums.

8 ___ Fewer benefits and lower premiums.

9 ___ Plan has outpatient prescription drug coverage and applicant
10 is enrolled in Medicare Part D.

11 ___ Disenrollment from a Medicare Advantage plan. Reasons for
12 disenrollment:

13 ___ Other reasons specified here: _____

14 *1. Note: If the issuer of the Medicare supplement policy being*
15 *applied for does not or is otherwise prohibited from imposing*
16 *preexisting condition limitations, please skip to statement 3 below.*
17 *Health conditions that you may presently have (preexisting*
18 *conditions) may not be immediately or fully covered under the new*
19 *policy. This could result in denial or delay of a claim for benefits*
20 *under the new policy, whereas a similar claim might have been*
21 *payable under your present policy.*

22 *2. State law provides that your replacement Medicare supplement*
23 *policy may not contain new preexisting conditions, waiting periods,*
24 *elimination periods, or probationary periods. The insurer will*
25 *waive any time periods applicable to preexisting conditions,*
26 *waiting periods, elimination periods, or probationary periods in*
27 *the new coverage for similar benefits to the extent that time was*
28 *spent (depleted) under the original policy.*

29 *3. If you still wish to terminate your present policy and replace*
30 *it with new coverage, be certain to truthfully and completely*
31 *answer any and all questions on the application concerning your*
32 *medical and health history. Failure to include all material medical*
33 *information on an application requesting that information may*
34 *provide a basis for the insurer to deny any future claims and to*
35 *refund your premium as though your policy had never been in*
36 *force. After the application has been completed and before you*
37 *sign it, review it carefully to be certain that all information has*
38 *been properly recorded. [If the policy or certificate is guaranteed*
39 *issue, this paragraph need not appear.]*

1 DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU
2 HAVE RECEIVED YOUR NEW POLICY AND ARE SURE
3 THAT YOU WANT TO KEEP IT.

4
5
6 _____
(Signature of Agent, Broker, or Other Representative)

7
8 _____
(Signature of Applicant)

9
10 _____
(Date)

11
12
13 ~~(g)~~

14 (f) No issuer, broker, agent, or other person shall cause an
15 insured to replace a Medicare supplement insurance policy
16 unnecessarily. In recommending replacement of any Medicare
17 supplement insurance, an agent shall make reasonable efforts to
18 determine the appropriateness to the potential insured.

19 ~~(h)~~

20 (g) For an individual who is subject to an open enrollment period
21 or who is guaranteed issue as described in Section 10192.11 or
22 10192.12, an issuer shall not use, for the purpose of determining
23 eligibility, the applicant's health information, including health
24 information acquired in compliance with the federal Health
25 Insurance Portability and Accountability Act of 1996. A statement
26 of this prohibition shall be included on the application form in
27 clear and conspicuous language, in addition to the open enrollment
28 and guaranteed issue periods described in Section 10192.11 or
29 10192.12. This subdivision shall not prohibit an issuer from
30 requiring proof of eligibility for a guaranteed issuance of Medicare
31 supplement coverage.

32 ~~SEC. 13.~~

33 SEC. 26. Section 10192.20 of the Insurance Code is amended
34 to read:

35 10192.20. (a) An issuer, directly or through its producers, shall
36 do each of the following:

37 (1) Establish marketing procedures to ensure that any
38 comparison of policies by its agents or other producers will be fair
39 and accurate.

1 (2) Establish marketing procedures to ensure that excessive
2 insurance is not sold or issued.

3 (3) Display prominently by type, stamp, or other appropriate
4 means, on the first page of the policy, the following:

5
6 “Notice to buyer: This policy may not cover all of your medical
7 expenses.”

8
9 (4) Inquire and otherwise make every reasonable effort to
10 identify whether a prospective applicant for a Medicare supplement
11 policy already has health insurance and the types and amounts of
12 that insurance.

13 (5) Establish auditable procedures for verifying compliance
14 with this subdivision.

15 (b) In addition to the practices prohibited by this code or any
16 other law, the following acts and practices are prohibited:

17 (1) Twisting, which means knowingly making any misleading
18 representation or incomplete or fraudulent comparison of any
19 insurance policies or insurers for the purpose of inducing or tending
20 to induce, any person to lapse, forfeit, surrender, terminate, retain,
21 pledge, assign, borrow on, or convert an insurance policy or to
22 take out a policy of insurance with another insurer.

23 (2) High pressure tactics, which means employing any method
24 of marketing having the effect of or tending to induce the purchase
25 of insurance through force, fright, threat, whether explicit or
26 implied, or undue pressure to purchase or recommend the purchase
27 of insurance.

28 (3) Cold lead advertising, which means making use directly or
29 indirectly of any method of marketing that fails to disclose in a
30 conspicuous manner that a purpose of the method of marketing is
31 the solicitation of insurance and that contact will be made by an
32 insurance agent or insurance company.

33 (c) The terms “Medicare supplement,” “Medigap,” “Medicare
34 Wrap-Around” and words of similar import shall not be used unless
35 the policy is issued in compliance with this article.

36 (d) The commissioner each year shall prepare a rate guide for
37 Medicare supplement insurance and Medicare supplement
38 contracts. The commissioner each year shall make the rate guide
39 available on or before the date of the fall Medicare annual open
40 enrollment. The rate guide shall include all of the following for

1 each company that sells Medicare supplemental insurance or
2 Medicare supplement contracts in California:

3 (1) (A) For policies sold for effective dates prior to June 1,
4 2010, a listing of all the policies, plans A to L, inclusive, that are
5 available from the company.

6 (B) For policies sold for effective dates on or after June 1, 2010,
7 a listing of all the policies, plans A to D, inclusive, F, F with high
8 deductible, G, and K to N, inclusive, that are available from the
9 company.

10 (2) (A) For policies sold for effective dates prior to June 1,
11 2010, a listing of all the policies, plans A to L, inclusive, for
12 Medicare beneficiaries under the age of 65 that are available from
13 the company.

14 (B) For policies sold for effective dates on or after June 1, 2010,
15 a listing of all the policies, plans, A to D, inclusive, F, F with high
16 deductible, G, and K to N, inclusive, for Medicare beneficiaries
17 under the age 65 that are available from the company.

18 (3) The toll-free telephone number of the company that
19 consumers can use to obtain information from the company.

20 (4) Sample rates for each policy listed pursuant to paragraphs
21 (1) and (2). The sample rates shall be for ages 0-65, 65, 70, 75,
22 and 80.

23 (5) The premium rate methodology for each policy listed
24 pursuant to paragraphs (1) and (2). "Premium rate methodology"
25 means attained age, issue age, or community rated.

26 (6) The waiting period for preexisting conditions for each policy
27 listed pursuant to paragraphs (1) and (2).

28 (e) The consumer rate guide prepared pursuant to subdivision
29 (d) shall be distributed using all of the following methods:

30 (1) Through Health Insurance Counseling and Advocacy
31 Program (HICAP) offices.

32 (2) By telephone, using the department's consumer toll-free
33 telephone number.

34 (3) On the department's Internet Web site.

35 (4) In addition to the distribution methods described in
36 paragraphs (1) to (3), inclusive, each insurer that markets Medicare
37 supplement insurance or Medicare supplement contracts in this
38 state shall provide on the application form a statement that reads
39 as follows: "A rate guide is available that compares the policies
40 sold by different insurers. You can obtain a copy of this rate guide

1 by calling the Department of Insurance's consumer toll-free
2 telephone number (1-800-927-HELP), by calling the Health
3 Insurance Counseling and Advocacy Program (HICAP) toll-free
4 telephone number (1-800-434-0222), or by accessing the
5 Department of Insurance's Internet Web site
6 (www.insurance.ca.gov)."

7 ~~SEC. 14.~~

8 *SEC. 27.* Section 10192.24 is added to the Insurance Code, to
9 read:

10 10192.24. This section applies to all policies with policy years
11 beginning on or after May 21, 2009.

12 (a) In addition to the requirements set forth under Sections 10140
13 and 10143, an issuer of a Medicare supplement policy or certificate
14 shall adhere to the requirements imposed by the federal Genetic
15 Information Nondiscrimination Act of 2008 (Public Law 110-233)
16 as follows:

17 (1) The issuer shall not deny or condition the issuance or
18 effectiveness of the policy or certificate, including the imposition
19 of any exclusion of benefits under the policy based on a preexisting
20 condition, on the basis of the genetic information with respect to
21 that individual or a family member of the individual.

22 (2) The issuer shall not discriminate in the pricing of the policy
23 or certificate, including the adjustment of premium rates, of an
24 individual on the basis of the genetic information with respect to
25 that individual or a family member of the individual.

26 (b) Nothing in subdivision (a) shall be construed to limit the
27 ability of an issuer, to the extent otherwise permitted by law, to
28 do either of the following:

29 (1) Deny or condition the issuance or effectiveness of the policy
30 or certificate or increase the premium for a group based on the
31 manifestation of a disease or disorder of an insured or applicant.

32 (2) Increase the premium for any policy issued to an individual
33 based on the manifestation of a disease or disorder of an individual
34 who is covered under the policy. For purposes of this paragraph,
35 the manifestation of a disease or disorder in one individual shall
36 not also be used as genetic information about other group members
37 and to further increase the premium for the group.

38 (c) An issuer of a Medicare supplement policy or certificate
39 shall not request or require an individual or a family member of
40 that individual to undergo a genetic test.

(d) Subdivision (c) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying the regulations promulgated under Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time, and consistent with subdivision (a).

(e) For purposes of carrying out subdivision (d), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(f) An issuer of a Medicare supplement policy or certificate shall not request, require, seek, or purchase genetic information for underwriting purposes.

(g) An issuer of a Medicare supplement policy or certificate shall not request, require, seek, or purchase genetic information with respect to any individual or a family member of that individual prior to the individual's enrollment under the policy in connection with that enrollment.

(h) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual or a family member of that individual, the request, requirement, or purchase shall not be considered a violation of subdivision (g) if the request, requirement, or purchase is not in violation of subdivision (f). However, the issuer shall not use any genetic information obtained under this section for any prohibited purpose described in this section or in Sections 10140 and 10143.

(i) For the purposes of this section, the following definitions shall apply:

(1) "Issuer of a Medicare supplement policy or certificate" includes a third-party administrator, or other person acting for or on behalf of an issuer.

(2) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.

(3) "Genetic information" means, with respect to any individual, information about the individual's genetic tests, the genetic tests of family members of the individual, and the manifestation of a

1 disease or disorder in family members of the individual. The term
2 includes, with respect to any individual, any request for, or receipt
3 of, genetic services, or participation in clinical research that
4 includes genetic services, by the individual or any family member
5 of the individual. Any reference to genetic information concerning
6 an individual or family member of an individual who is a pregnant
7 woman includes genetic information of any fetus carried by that
8 pregnant woman, or with respect to an individual or family member
9 utilizing reproductive technology, includes genetic information of
10 any embryo legally held by an individual or family member. The
11 term “genetic information” does not include information about the
12 sex or age of any individual.

13 (4) “Genetic services” means a genetic test, genetic education,
14 or genetic counseling, including obtaining, interpreting, or
15 assessing genetic information.

16 (5) “Genetic test” means an analysis of human DNA, RNA,
17 chromosomes, proteins, or metabolites, that detect genotypes,
18 mutations, or chromosomal changes. The term “genetic test” does
19 not mean an analysis of proteins or metabolites that does not detect
20 genotypes, mutations, or chromosomal changes; or an analysis of
21 proteins or metabolites that is directly related to a manifested
22 disease, disorder, or pathological condition that could reasonably
23 be detected by a health care professional with appropriate training
24 and expertise in the field of medicine involved.

25 (6) “Underwriting purposes” includes all of the following:

26 (A) Rules for, or determination of, eligibility, including
27 enrollment and continued eligibility, for benefits under the policy.

28 (B) The computation of premium or contribution amounts under
29 the policy.

30 (C) The application of any preexisting condition exclusion under
31 the policy.

32 (D) Other activities related to the creation, renewal, or
33 replacement of a policy of health insurance or health benefits.

34 ~~SEC. 15. It is the intent of the Legislature to enact legislation~~
35 ~~that would make the changes required by the federal Medicare~~
36 ~~Improvements for Patients and Providers Act of 2008 and the~~
37 ~~federal Genetic Information Nondiscrimination Act of 2008 to the~~
38 ~~Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2~~
39 ~~(commencing with Section 1340) of Division 2 of the Health and~~
40 ~~Safety Code).~~

1 *SEC. 28. No reimbursement is required by this act pursuant*
2 *to Section 6 of Article XIII B of the California Constitution because*
3 *the only costs that may be incurred by a local agency or school*
4 *district will be incurred because this act creates a new crime or*
5 *infraction, eliminates a crime or infraction, or changes the penalty*
6 *for a crime or infraction, within the meaning of Section 17556 of*
7 *the Government Code, or changes the definition of a crime within*
8 *the meaning of Section 6 of Article XIII B of the California*
9 *Constitution.*

10 ~~SEC. 16.~~

11 *SEC. 29. This act is an urgency statute necessary for the*
12 *immediate preservation of the public peace, health, or safety within*
13 *the meaning of Article IV of the Constitution and shall go into*
14 *immediate effect. The facts constituting the necessity are:*

15 *In order to make the changes required by the federal Medicare*
16 *Improvements for Patients and Providers Act of 2008 and the*
17 *federal Genetic Information Nondiscrimination Act of 2008 by*
18 *the dates imposed under those acts, it is necessary that this act take*
19 *effect immediately.*